VOLUME III—Pages 718-951
APPENDIX

IN THE

Supreme Court of the United States

October Term, 1975

NO. 75-1690

T. M. "JIM" PARHAM, Individually and as Commissioner of the Department of Human Resources, W. DOUGLAS SKELTON, Individually and as Director of the Division of Mental Health and W. T. SMITH, Individually and as Chief Medical Officer of Central State Hospital,

Appellants,

v.

J. L. and J. R., Minors, Individually and those representatives of a class of persons similarly situated,

Appellees.

APPEAL FROM THE JUDGMENT OF THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF GEORGIA

APPEAL DOCKETED MAY 21, 1976
JURISDICTION NOTED MAY 31, 1977

TABLE OF CONTENTS

VOLUME I

VOLUME II

TABLE OF CONTENTS—Continued

IN THE

Supreme Court of the United States

October Term, 1975

NO. 75-1690

T. M. "JIM" PARHAM, Individually and as Commissioner of the Department of Human Resources, W. DOUGLAS SKELTON, Individually and as Director of the Division of Mental Health and W. T. SMITH, Individually and as Chief Medical Officer of Central State Hospital,

Appellants,

v.

J. L. and J. R., Minors, Individually and those representatives of a class of persons similarly situated,

Appellees.

[1]

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

The deposition of DR. JOHN PATON FILLEY taken before Phillip Roger Scott, Certified Court Reporter, commencing at 9.00 a.m., December 10, 1975 at State Judicial Building, Atlanta, Georgia.

---

[2]

APPEARANCE OF COUNSEL

For the Plaintiffs:

NANCY LINDBLOOM, Attorney at Law
Georgia Legal Services Programs
Macon Regional Office
653 Second Street
Macon, Georgia 31201
DAVID GOREN, Esquire
Georgia Legal Services Programs
Macon Regional Office
653 Second Street
Macon, Georgia 31201

For the Defendants:

DOROTHY KIRKLEY, Attorney at Law
Assistant Attorney General
132 State Judicial Building
Atlanta, Georgia

[3]

CONTENTS

[4]

PROCEEDINGS

MS. KIRKLEY: The stipulations are that all objections, except as to the form of the question and responsiveness of the answer, are reserved until the week after filing when we will file objections in writing.

Whereupon,

JOHN PATON FILLEY

was called as a witness and, having first been duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MS. KIRKLEY:

Q Would you state your full name for the record.

A John Paton Filley. Paton is (spelling) P-a-t-o-n.

Q What is your profession?

A I'm a physician and psychiatrist.

Q And, where were you educated, Dr. Filley?

A I went to Yale University for my undergraduate education. Yale University School of Medicine, medical school. Interned in pediatrics at University of Minnesota Hospital and did two years of general psychiatry and two

years of child psychiatry training at North Carolina Memorial Hospital.

Q Are you a Board certified psychiatrist?

A I'm Board eligible.

Q You're Board eligible.

[5]

A I have the training requirements and experience requirements.

Q For both general psychiatry and child psychiatry?

A Yes.

Q But, you have not received certification in either?

A That's right.

Q Is that correct?

A (Nodding head affirmatively)

Q Where was your training in child psychiatry?

A At North Carolina Memorial Hospital which is training center of the North Carolina Medical School.

Q When did you complete that training?

A Completed training in 1957.

Q And, what employment have you held since that time?

A I was on the faculty of the child psychiatry program there at North Carolina Memorial for one year and then went to the School of Public Health, University of North Carolina where I was faculty member and head of the department of mental health for 16 years until I left last summer to come here to Georgia.

Q And, so, you've been here for about—

A Almost a year and a half.

Q And, again what were you the head of?

A I was head of the mental health department for 8 years and then a faculty member in the School of Public Health.

[6]

Q What did that position involve? What were your duties there?

A The program of the department was addressed to primarily the teaching of students in the school of public health about issues related to mental health, aspects of the field, the development of the field, the approach of mental health in trying to deal with problems on a total community basis.

Part of the time our program was for general public health students. During the latter years of the program we had a specialty program in mental health; and we were taking students and training them for masters and doctorate degrees in public health and major in mental health.

Q Did you teach any medical students?

A Only very occasionally was I involved with medical students. Many of our students in the School of Public Health were physicians doing post-medical training.

I supervised residents in child psychiatry for a number of years in therapy and became involved in seminars and so on with the community psychiatry program. We had a reciprocal relation between our program in public health and community psychiatry.

Q Have you ever practiced psychiatry privately?

A During the years I was on the faculty of the School of Public Health I kept a small amount of private [7] practice going all the time.

Q Do you have any idea what your average case load was?

A Small, I carried 2 or 3 or 4 patients at any one time.

Q And, what are the responsibilities of your present job?

A In general to oversee and direct the development of child and adolescent programs in the mental health field for the State of Georgia. It's stimulating, directing, providing research education. Looking after budgetary considerations; working on the development of the general program of the Division of Mental health with particular reference to applications to child and adolescents. I get involved in division committee activity. I've been on the division committiee on development of information system, the committee on the development of confidentiality policy, division committee on the development of training policies.

Q What's the official title of your current position?

A I'm Director of the Office of Child and Adolescent Mental Health Services, Atlanta Division.

Q And, could you describe please the present state program for children and adolescents in the Mental Health Division.

A As is generally true across the country, it's lagging [8] somewhat behind general adult mental health at this point. Within the framework of the division we intend to have a unified system of services that includes hospital and community services. We have hospital services in 7 of the 8 regional hospitals and are working towards getting services in the 8th. We have some representation of child and adolescent services in all 34 catchman areas in the state at the community level. These vary from very

nominal, a few staff in mental health who work with children to quite well developed programs in some of the areas with a sizeable staff whose responsibility and whose child and adolescent services are quite extensive.

Q In the present system what are the criteria for hospitalizing children in a regional hospital?

A The intent has been when in the judgment of the community program a period of hospitalization would be the most appropriate form of care. We haven't arrived at that point fully yet. We still get patients who are referred directly to the hospital by various people from the community and sent there by judges and so on without recourse through the community.

We're significantly increasing the extent to which the referrals do go through the community program. When at the discretion of the community program there's some reason in the case that hospitalization would be appropriate at that [9] time, then he goes to the hospital.

Q I realize this is a very broad question, but when you say, "Hospitalization is the appropriate treatment," could you be somewhat more specific about the kinds of situations in which hospitalization becomes appropriate, what the family situation might be, why hospitalization is preferrable at that time in the child's life.

A It can be quite a variety of circumstances that can make it appropriate for a child to be hospitalized. One would be a very acute, severe degree of disturbance. The child's behavior is quite out of control, and he needs to be in a contained environment until some stabilization is achieved through medication, through program and therapy and so on that brings about a greater degree of capability on the child's part to function within normal controls.

Other situations, due to social circumstances the child's interaction with his parents may be in sort of a vicious circle pattern where it's getting worse and worse; and the parents are not able to change or interrupt this vicious circle; and a disturbance builds. It may be appropriate to hospitalize the child as part of breaking that cycle and achieving a more stable relationship.

The broad general statement would be that these would be the two major conditions in which we say hospitalization is appropriate.

[10]

Q You described—

A To the extent that one other step, the child who is not in his own familiar home, the child has been taken into custody and so on. Very often in that situation there is less capability of the social group to deal with the child. A natural family is apt to be more tolerable of this disturbance than foster parents. Then, the social situation breaks down; and as a way of trying to get some usability in the situation and enable the child to return and function in the community, it may be appropriate to hospitalize the child.

Q You described the first situation as where there was an acute problem that required hospitalization. Would you say that was an emergency admission?

A We tend to use emergency admission as one which within a matter of hours, less than a day, a person ought to be gotten into the hospital because there is some serious risk for the child. The child is running away and getting into a very hazardous situation, violence where there might be danger and so on. So, we tend to think of emergency in those terms.

Many of these situations might be tried in the community basis, in a community program for a number of days or even a couple of weeks before a decision was made that it couldn't be managed in that way. So, even in that first category where it's fairly severe disturbances, it wouldn't [11] always be handled as an emergency admission, say, within 24 hours.

Q Is there a policy that treatment should first be tried in the community and in the home prior to hospitalization?

A There is a policy that says a judgment should be made; if possible, treatment should be tried in the community. I don't see and I wouldn't promote a policy that would say it should always be tried first. A clinical judgment in this case, as I see it, the child from the first contact, the first evaluation shows the most appropriate treatment as hospitalization.

Q Do you have any written policies that state what you've just expressed as in regard to standards for hospitalization?

A Not specifically in regard to children and adolescents. There's a statewide policy. We have some general policies and divisional policies; and they state things of this general sort; and those are applicable to the child and adolescent programs. But, we don't have specific policies at this time.

Q Do you do training programs for mental health professionals in children and adolescent programs?

A Yes, we were fortunate in being able to identify some funds for the last fiscal year, fiscal '75. We did five statewide training programs of personnel in child and [12] adolescent programs.

Q Give—

A We're less able to do that financially this year. We've just finished one yesterday that was not so much a

training program as a working conference and the development of plans for child and adolescent services on a regional basis. We're anticipating conducting a training conference on the rights of children in the mental health system in January.

Q In training sessions such as these do you discuss the standards for hospitalization and the use of community resources when appropriate?

A Yes, there are many discussions around these sorts of issues. Child and adolescent services has a clearly differentiated focus of service. They have only been in that status since my office was created less than a year and a half ago. There has only been specific funding identified for the development of child and adolescent programs in communities for two and a half years in the State of Georgia. And, when we started the training conferences, last year was really the first time that people had begun to get together outside of their local programs very extensively. And, so, we've been through a process over the last year and a half which has been a great deal of work, trying to work out better and more functional relationships between community [13] programs and hospitals and guidelines on which services belong in what place, how to more effectively work out transfers between parts of the system. It has been a very significant issue and has been discussed recurrently.

Q Have any written statements or policies come out of these sessions yet?

A Not general statewide ones. Our focus has been one of central effect with local autonomy. And, there have been a number of working agreements and so on that have started out of these conferences. People have gone back and worked in their own region between the hospital and

community programs various policies and region agreements and so on of how they would function. But, no statewide statements of that sort.

Q Are there differences among the 8 regions which require this kind of local approach?

A Very considerable differences. Atlanta Regional Hospital serves 10 almost entirely metropolitan catchman areas. They do reach out a little bit into the non-metropolitan areas out in Douglas County, for instance, which I guess is still part of the standard metropolitan district although it gets quite rural. But, southeast Georgia, the Savannah Region has 2 huge catchman areas that are extremely rural and a third which is largely rural and only one metropolitan.

These require different approaches in how you reach [14] the people and how you place facilities close to them and resources you have to call on and so on.

Q So, you have worked mostly in outlining the general approach and helping the different regions—

A Develop their own perspectives, yes.

Q Is part of the standard for admission of children to the hospital on the application of their parents or guardians that they're dangerous to themselves or others?

A I would say that is a fairly rare thing for children. There are certain examples where a child is excessively aggressive and he's dangerous. Or, has a pattern of running away where he could easily get himself into situations where—that are dangerous to himself. Rarely do we see a child who is suicidal. It occurs, but it's not a common danger. So, the frequency for that kind of condition for hospitalization is probably less with children than it is with adults.

Q And, if the children are not dangerous to themselves or others and excluding for a minute that type of admission to the hospital, when in the professional judgment of the psychiatrist especially in the state system is hospitalization indicated?

A You could almost take the word dangerous and translate it somehow—when the child-parent interaction for whatever reasons, whether it's some factor in the child that may be unavoidable or some pattern of interaction the parents [15] and child have gotten into, is thoroughly blocking his development, so he's not progressing. This can be very dangerous to the child's life situation, although it's not acutely a hazard to his life; but, a significant disruption of a progressive growth oriented child-parent interaction, we would view as quite a dangerous thing in the longer perspective of the child's life. That would be one of the major considerations.

Q Is it important in your opinion that a child be given psychiatric treatment at that stage rather than waiting until it becomes eminently dangerous?

A We would like to become involved earlier than that, if at all possible, when the pattern may have started developing. This is one of the reasons we emphasize as much as we're able to outreach programs. We make contacts with school teachers and other people working with children in the community, so as early as possible there can be an identification of some insipient problem and hopefully some kind of intervention then. That may not be in the form of psychiatric treatment. It's more with the teachers or with the social workers or parents to try to interrupt the pattern which is building.

Q What is the basic reason for the expansion of services to children and adolescents?

A Well, the basic reason for the expansion is because, [16] as we have come to see the situation, it appears that provision of these services can be helpful to children and their families and can make significant differences in how their lives progress and be more effective and satisfied people. And, we're not doing nearly enough of it.

The child and adolescent services proportionately are, as I said earlier, quite a bit less developed than general adult services. I did some figuring a year ago on the basis of the 1974 out-patient statistics; and there were, I think, catchman areas in the state that were providing roughly proportionate services in the terms of the size of child and adolescent population, which would say we ought to be providing about 35% of services to children and adolescents. Actually, in many of the catchman areas it was one-tenth or less as much service for children and adolescents as for adults.

Q Is one of the reasons for expansion the early intervention might prevent problems that later in adult life would become more dangerous?

A This is still one of the hypotheses we're working on, not that it's really documented or proven. There haven't been enough of these services or long enough to really know. That's a problem with social experiment; when you try to do something of a major sort of a change in society, it's years before you know what's really done. [17] I think there are sufficient reasons to believe that it's an appropriate direction to be going with that intent. With the intent that intervention in its early stages can reduce the difficulties later. But, I'd say it's still in a stage of a hypothesis. We don't have sufficient documentation to stand on absolutely.

Q I'd like to talk for a few minutes about diagnosis in children and adolescents. And, we have gotten all the statistics from the 7 regional hospitals and the certain categories of mental illness that show up that will perhaps be helpful if you describe what those mental illnesses involve.

The first one is schizophrenia.

A Schizophrenia is a complex idea in any mental health field. It has—The term has been applied to a variety of situations in children; some of which for, say, an adolescent child might be quite closely analogous to what we call schizophrenia in adults. The word is used with younger children specifiying childhood schizophrene, but the picture is quite different.

Childhood schizophrenia is diagnostically what we use for some conditions in which from birth the child is one to which the parents can't form a close relationship. The child is in a variety of ways less flexible. The child is sometimes physically even rigid. You pick the child up and try to cuddle it, and he's just stiff. In other ways when [18] the parents try to interact with the child, they don't get the responsiveness. He is less responsive than normal children. And, some of these children, we usually don't see them until their a year and a half, two or three years old. The parents give a history of the child having been unresponsive, stiff, untouchable almost from birth.

Now, in other circumstances we see children who may have developed apparently quite normally through say the stage of beginning to learn to talk, 15 to 18 months; using some words and then for some reason the child stops using words and becomes more and more withdrawn from the usual, expectable behavior of a child

of this age, and may get further into a situation where he goes about his activities during the day maybe in ways that show no significant difference in human beings and physical objects. He treats people as if they were objects, and he doesn't show a difference. He has not somehow further developed those patterns of functioning that say a person is something unique; and you respond to it one way; and you respond to chairs and tables in other ways. And, such children may get into patters of repetitive head banging and very highly repetitive activities. We refer to this as autistic. We're saying that the child is contained within himself and involved with his own inner processes, rather than sensitive to and responsive to the processes going on in the world around him.

[19]

There are several patterns of this sort that we lump together as childhood schizophrenia. We say that in some sense they are analogous to what we see in adult schizophrenia.

In the long run we may find that it is a very different condition. The notion of common path comes up in a lot of notions. There may be a variety of things that have led to it. But, there are some things about them that are similar. In this case, the failure to interact with the surrounding world with the usual sense of reality of what the world is. Autistic children are not interacting in a realistic way with the world around them. The conventional notions of reality, just as an adult is hallucinating and expressing delusionary ideas, he's not interacting with the world in a realistic way. But, that analogy leads to the use of the same term. It may not be the same condition.

Q Is autism—

A Autism is within the category of childhood schizophrenia.

We also speak of the symbiotic child who has a very special and limited social limitation, intense interaction with the motherhood figure. When the child's behavior becomes very severely disorganized when he is removed from that one interaction, then it's not a usual development of social interaction, although there is a limited situation with that [20] one person.

Q What about when you get to adolescents with schizophrenia?

A The diagnosis of schizophrenia in adolescents is much closer to the diagnosis used in adults. It's based on typically on evidences of a distortion of reality and thought processes and changes in affective behavior to a degree when the usual ups and downs of mirth and sorrow and fear and so on, just sort of a steady unresponsiveness. But, in adolescents we would see delusional thoughts that would be definable; hallucinations is among the indicators that would lead to the diagnosis of schizophrenia.

Q Another major mental illness that appears from the records is adjustment reaction of childhood and adjustment reaction of adolescents. Would you describe what those are?

A In child mental health almost everything that has been done started from people who worked with adults and then began working with children in trying to see how to move the concept in mental health to apply to children. It doesn't work. Just taking notions of adult mental health and applying them directly to children just doesn't work.

People begin to see youngsters who might show quite significant evidences of disturbance which seem to

be very much related to their developmental stage, where they were in their growing up processes and when observed over a [21] period of time would resolve themselves in some sort of way over a period of time. Sometimes a fairly short period of time.

And the developmental disturbances of childhood or adolescence, there are ways of trying to characterize those. Occasionally, particularly in later adolescence we may even see something for a period of days or a week as the manifestation of a psychosis or schizophrenia but resolves itself fairly quickly.

More characteristic what we see is a very aggressive, intense, aggressive response, withdrawn response, a variety of different behavioral patterns. In effect the statement is a prognostic one. It's an effort on the part of the diagnostician to say, "As far as I can judge, putting all the picture together, the behavior I see and the history I gain, the evidences I see of the parent-child interaction and so on, this is a condition that I predict will clear up with not too much intervention." I think again it's somewhat hypothetical to say that when a condition like this occurs a variety of outcomes can follow. And, intervention at that time is intended to see that the outcome is a reasonably healthy, progressive one. It may be acute manifestations of the adjustment reactions may disappear with the child settling into a more fixed behavioral pattern of overt rebellion or of submission or something of that sort, which probably would [22] not be a healthy or as healthy an outcome. So, intervention is designed to try to assure when the expected resolution occurs, what comes out will be a reasonably good one for the child's continuing development.

Q You mentioned one of the symptoms might be

intense aggressive behavior or manifestations of what looks like schizophrenia. Are there any other kinds of behaviors or moods that might appear for a child who has been diagnosed as having an adjustment reaction?

A Yes, the child could just be showing a lot of anxiety. This could be a nervous mannerism, overt anxiety, profuse sweating. Probably not in a child much under adolesence would you see that sort of reaction. It's more typical as the child gets older. Withdrawal, excessive fantasy involvement, imaginary companions, almost any kind of behavior that a child is capable of can appear in excess.

Q What about depression?

A We see very little overt depression that we can compare well with depression in adults in children before adolescence. You begin to see some in adolescent children. I've seen, I guess, in my entire career one child who was probably at the time 10 or 11 who was overtly suicidal; and he took a rifle and managed to put a bullet through his shoulder. But, young children don't—Well, their capability to be depressed seems to be a developmental thing that hasn't [23] arrived.

Q As we've discussed and you've mentioned some differences between children and adolescents with regard to adjustment reaction. Can you think of any other that might make the diagnosis different between children and adolescents?

A Well, the primary reason for the difference in the labeling is simply the developmental stage of the child. It has to do with the developmental capabilities of the child and what kind of social interaction he's apt to be engaged in. No gross depression in younger children. People somehow interpret depression in the younger child.

They say this withdrawn behavior we say is because of an inner depression. But, this is not because the child says, "I'm blue; I'm down in the dumps," or that the child cries or does the kinds of things that we would say, "that's depression." So, some people say of a quiet withdrawn child that he has an inner depression.

Q Does the diagnostic label of adjustment reaction in and of itself say anything about the severity of the symptoms?

A No, unless that's qualified.

Q What about hyperkinetic reaction of the child, what symptoms?

A This is a somewhat confused term, because the notion of hyperactivity associated with minimal brain damage [24] which was developed relatively recently comes into the picture. But, hyperkinetic simply means overactive. Anything in which there is a degree of motor activity that is considerably greater than normal could be classified as a hyperkinetic reaction. There's nothing in that diagnostic counterclaim that says there has to be brain damage in that particular pattern.

Q It's a description of symptoms?

A Yes.

Q Of behavior?

A Yes.

Q There is a classification of personality disorders. Do these usually appear in children and adolescents?

A I think the term is considerably less used since TSM2 came out in 1968 or something; revision of the diagnostic statistical manual introduced a much more

extensive way of looking at adjustment reactions. The difference in the ideas behind these is that a personality disorder is seen as one in which a pattern of functioning has become quite fixed within the person's makeup and as a persistent way of that person's interacting with other people. It's likely to go on over years. It's a part of the makeup.

I think this is not very commonly used now in children. It is used to some extent in adolescents and probably a more applicable term for adults when personality qualities [25] are more fixed and do tend to persist longer.

And people have used the adjustment reaction of childhood as a much more relevant way of looking at what you see in a child who seems to be changing anyway with this developmental progress.

Q But, at the time that label is fixed is that basically a statement that from everything known those symptoms are not fixed and probably will go away eventually?

A The personality disorders?

Q Adjustment reaction.

A That's a prediction that's made looking at the total picture. Whereas, diagnosis of personality disorder would be because the history indicates that this has been persistent through a variety of circumstances over a period of time and it looks as though it's likely to keep on characterizing a personal functioning.

Q So, you might first give a diagnosis of adjustment reaction of childhood or adolescence and then later, if the same pattern persisted, change that to a personality disorder.

A Correct.

Q As it became fixed.

A Right, that would be probably a quite appropriate change of diagnosis. The tendency that is present in the field to try to make the least pejorative diagnosis at the first instance. I think this has not been true of the [26] field forever when people were looking for more rigorous ways to classify things and trying to get them in categories much harder, working at it much harder than we are now as a way of trying to understand what we're dealing with. They perhaps did tend more to say, "Uh-huh, I see a little bit of a sign here that says it ought to be classified as schizophrenic." Whereas, the tendency more recently has been in the direction of trying to put the least pejorative, severe label on things. So, people will tend to say adjustment reaction to child and adolescents and only in the light of early experience. You say, "well, that was a bad estimate at that time; or something else has gone on; and now we have to change it to a more persistent, serious kind of labeling."

Q So, would you categorize the adjustment reaction diagnosis as being a conservative one?

A Yes.

Q Can you think of any other major categories of mental illness of children and adolescents which need to be described?

Q We haven't talked at all about neurosis. This is another concept which generally refers to a less serious condition than a psychosis, which refers to a condition that is seen as probably being more transient than a personality disorder, on the average more transient, which is thought of as being more of an intrapsychic distortion, say, than the [27] typical adjustment reaction.

Adjustment reaction tends to be more in a variant social behavior that's fairly extreme. But, the neurosis may be such a thing as a conversion reaction, a hysterical neurosis in which—well, an extreme case say blindness. A person acts and believes himself to be blind. They deny any ability to see things in front of them. As far as we can make out, they're not lying. They're not faking it, although if you get them up and lead them across the room, they will somehow or another manage to sidestep an obstacle on the way. But, as far as their consciousness is concerned, they're not seeing.

There are a variety of other neurotic reactions.

Q Would these become a diagnoses for children or adolescents?

A Hysterical conversion reaction is probably a fairly common circumstance of early teenage youngsters. It's an interesting thing it was a common diagnosis 75 years to a hundred years ago. When I came to North Carolina for my psychiatric training, it was at a time when most of the leading working psychiatry in this country had been done in the Northeast, northcentral states, the West; and there hadn't been a great deal in the South. And, people were saying hysteria used to happen back in Freud's day; but it doesn't any more. It's a very rare condition.
[28]

A study was done in North Carolina that showed something like 13% of the teenage kids coming through the out-patient mental health program there in the psychiatry department had behavior and functioning that was appropriately diagnoised as hysterical. It seems to be associated with more fundamentalistic religious views, less advanced modern social circumstances. You find it in rural populations where there's a high level of fundamentalist belief and so on.

Q You mentioned blindness is one type of hysterical reaction. Are there other common ones?

A The term is used to apply to situations in which there is change in the person's perceived sensory function or their voluntary motor activities, that is, as far as one can make out, due to psychological factors, not to any somatic changes. So, it can involve pseudoconvulsions of motor activity. It can involve paralysis or lack of motor activity, a paralyzed limb. It can involve unusual or strange sensory experience such as perception of and reporting of pain or anesthesia, inability to feel anything with the hand, say. It can mimic many neurological conditions. But, when the evaluation is done, no neurological evidence is found. For instance, neurological damage can result in anesthesia of a part of the hand; but there's almost no neurological condition—there is no neurological condition that can result [29] up to this point (indicating) and going no further. There are persons who say that I can't feel anything from here down. And, you can stick them with pins; and they don't jump. Yet, there's no way neurologically that it can happen on that basis. So, that covers that range of conditions.

Q You think that pretty much covers, say, 90% of the diagnoses?

A The psychosis, neurosis, personality disorders and adjustment reactions. We could get into some psychosomatic disorders, childhood dermatitis, a variety of psychosomatic disorders in which there is pathological change in the body tissue and so on, which appear to be to a significant extent due to psychological reactions in the person's life.

Q Would these be admitting diagnoses to the regional hospital in the psychomatic illnesses?

A I am not aware of that being admitting diagnosis to the regional hospital. That would be more often seen in a pediatric hospital. The pediatrician might call in psychiatric help. It wouldn't be one of the things for admission. It very rarely crops up. I'm not aware of any case that has been admitted since I've been here.

Q Doctor Messinger who testified in this case characterized adjustment reaction of childhood and adolescence and hyperkinetic reaction as being rather benign and common diagnoses. In your opinion, would the fact they're common [30] diagnoses affect need for hospitalization in individual cases?

A No, depending on the total judgment of the circumstances and the sort of condition are grounds for hospitalization. There's no reason why it shouldn't be appropriate for hospitalization; some of the time the diagnosis is not that important in the hospital decision. It's the judgment of the total circumstances.

Q Well, how important is it that two psychiatrists might put a different diagnostic label on the same symptoms?

A Well, I don't think it should be too important. Certainly, we ought to be trying to standardize diagnoses, so we can arrive at better judgments, where we can be more consistent. That will be the millenium when we can do that, when we know what these things are all about so well that we can put a clear common label that has meaning in terms of what we do and so on.

Unfortunately, I think we've been overfocused on the medical model as the only consideration. That is we have looked for conditions that were analogous—But, it's increasingly apparent that the conditions we're talking

about are ones that have multiple factors involved and complex reaction patterns to a total somatic, social, psychological context. And, we probably haven't gone far enough in adding diagnoses of family or action patterns or other things to our categories, [31] ways of characterizing as we see them. If the family interaction pattern is really side-tracked, and the overt manifestations are relatively mild in the child, that can be a very serious circumstance, although the label itself looks very benign.

Q For example—

A I think almost anybody in the field today is really looking at things as much as they can in that kind of a way. We have to go back to using labels that have a long history of evolution and derived at a certain point. The Joint Commission Standards on Accreditation of hospitals —we have to have diagnostic labels, and those diagnostic labels have come about from a medical framework, a medical perspective and assume a certain form that's obligatory to meet certain standards and that has a certain utility.

Q But—

A It isn't the whole picture, and we need to go very much beyond that. So, you're going to get variations in diagnoses. Probably if you ask many psychiatrists who are using different labels what they're going to do about a thing, what they think would be the appropriate action, you'll find that many cases there'll be much more agreement than in labelling of children. They'll say, "Yes, this child belongs in the hospital," although they might be using different labels to say so.

[32]

Q Well, then how would the child be treated once

he was in the hospital? What difference would the label make with respect to treatment?

A Certainly, in cases where the dianosis is quite clear and where many people would agree on it, the label would make some difference in diagnosis. Even in more uncertain cases the labeling may suggest some direction in trying treatment. There are certain drugs that are by experience considerably more effective for people who are psychotic, the major tranquilizers. The minor tranquilizers would be more appropriate to use in cases of anxiety, hyperactivity and so on. If the hyperactivity is specifically the kind that is associated with minimal brain damage, there are other things. So, the diagnosis can make some difference In terms of a general psychological or social minute treatment of a child, there probably is ostensibly less difference.

An environment that is concerned about disorders of behavior, that is interested in feelings, that encourages constructive interaction with your peers or with the authority figures around you is probably more generally applicable to almost anything we see. We may make some differences depending on individual circumstances. A severely inhibited child, we'll try to more actively bring out in the open; and a hyperactive or hyperaggessive child, we might try to draw out certain things while controlling others. Try to teach [33] the child the difference between total expression and expression of certain portions. So, we do make some differences. Again, not so much related to the diagnosis in the management of the child as related to his particular circumstances, particular areas in which he appears to be having problems in interaction with other people and so forth.

Q Would the diagnostic lavel of adjustment reaction, which can cover a number of behaviors and symptoms, what kind of treatment would be indicated?

A There's a range of treatments that might be considered appropriate under various circumstances. It would depend partly on—Well, say a private facility that could limit the number of patients it took and provide a long term treatment, they might take a child like that and over a period of a number of weeks or even a number of months involve the child in individual play therapy to express as much of what was behind his behavior problem and try to resolve it with that sort of approach. Where we have to—Well, another program might also be functioning on a private basis with as much resources as they needed to do it and be using a behavioral modification approach where they would try to as clearly as possible identify where the child's behavior is going wrong and then foster alternative behaviors, positive reinforcement alternative behaviors. This probably is on the average a more rapid kind of treatment. And, empirically, [34] I don't know of any evidence there's any as good. There are certain theoretical positions from which people say that's bad and this is good. But, it seems to work. And, I don't know if we know enough about the total progress of a person's life to really say—

Q One child that's diagnosed with adjustment reaction might be aggressive, and another child might be withdrawn.

A Uh-huh (affirmative).

Q And, their treatments would be based on a particular behavior that they're showing.

A Uh-huh (affirmative).

Q Disregarding diagnostic—

A What's needed to get them back to a more functional way of behavior.

Q In treating children and adolescents what difference

does it make to treatment that the child initially does not want to be treated, does not want to come to a psychiatrist, or does not want to come to the hospital?

A My experience, it's very rare for a child to ever want to be treated to begin with. Children in our society and probably in most are very used to being pushed around a good deal by their parents. They are taken to school because the parents say, "you're going to school;" which may in some instance be because the law says, "If you don't take your kids to school, we'll do something to you." But, there is a [35] whole set of things in leading to why a child goes to school and what's expected of a child in school. Children, depending on their age and families, go on vacation with no decision in the process. They are treked around where the parents want them to go. When children are brought for treatment, it's part of this whole context.

I've found children who after some several visits begin to find it's kind of fun to go see the shrink. He's kind of a neat guy; and, you know, they enjoy coming. But, it's very rare to find a 7 or 8 or 9 year old child who even after quite a long time and quite positive relationships could say why he is coming and be electing to come to deal with his symptoms, to deal with his disorder.

Q What about an adolescent, say, a 14 or 15 year old?

A By around 12 or 13, 14 certainly, you find that some kids who can make the election, who can in a positive sort of way say, "I have something wrong with me; I want somebody to help me with it." I'd say it would be very rare before 12, becoming of some significance beyond 12.

Q What about treatment of adolescents who are saying that they don't want to come?

A If I'm treating a youngster of that age, I would very much like to fairly quickly arrive at the point where he says, "Okay, you know, I'm with it;" and treatment will progress better. But, I have to go by my best judgment of [36] the situation as to how disordered the child's functioning is. And, if my clinical judgment is that it's a serious disorder, that it's going to be significantly impairing of the child or if the manifest disorder is relatively mild but the interaction in the family is of the sort that's likely to perpetuate or aggravate and develop into something more serious, then I would go along with the parents' wish to have the child treated, whether the child wants it or not. And, that would be my job to work through that resistance as well as I could and get the child involved in positive progressive treatment processes.

Q In your training in child psychiatry were you trained to get through their resistance?

A Yes, this is a normal part of the approach in training. This is something that you have to do.

Q What about other mental health professionals, other than psychiatrists, would they also have received training in how to get through the resistance of children and adolescents?

A A huge discussion of literature, much involvement in training and so on is how you work with this type of patient.

I remember one person in a training session when I was presenting a case I was working with, specifically, the question, "Do you ever expect to have any sickness insight on [37] the part of this patient; do you expect this patient to know that 'I am sick' and to receive treat-

ment?" It was a very severely disturbed young child. There's no way that—That was a childhood schizophrenic.

Q Are you familiar with an article by Rosenhan called "On Being Sane in Insane Places?"

A Yes, it appeared—

Q Could you just describe briefly what that study was.

A This a study which is minimally reported in Science in terms of the detail of how the detail of how the study was carried out in which 8 people who functioned as voluntary subjects in the experiment made appearances at hospitals. They requested a chance to come in for evaluation. They went for the evaluations. It doesn't report the details in terms of—he says 8 people went to 12 hospitals. Some of the people must have gone at least twice. I don't know how many of them. Whether one of them went 5 times and all the others went 1 time or what. They appeared at the, I suppose, the admissions office of the hospital. He didn't specify whether it was the out-patient clinic or the hospital or whether it was the admissions office or what. And, they said, "I am hearing voices." When asked, they said the voices said, "Thud, empty—" There was another word. And, at some point in what went on, they don't indicate in the report [38] how long the interviews were or anything else; but at some point hospitalization was recommended. And, the people who volunteered accepted hospitalization; and they were admitted to the hospital for a period of time.

Q Do you have any opinion with regard to the methodology used in that study?

A It's a pretty limited methodology, because it tried one thing and based the findings on what happened. Now, there is no comparison of what would happen if alternatives had been attempted. The report, as I say, is a very limited report and very little detail given. They report certain things that were done and certain consequences that followed but almost nothing about all of the surround that must have been there. I can't conceive anybody going up to hospital admissions office and saying, "I hear a voice and thud;" and somebody saying, "Gee, you'd better get in the hospital." It must have been a much more extensive process.

Q Well, in your experience would you have expected a sane person to come to the hospital reporting such symptoms with the purpose of getting into the hospital?

A No, I wouldn't expect a sane person, no. Well, that gets into what you mean by sane. Sane is a legal term really, not a psychiatric term.

Q Well, in psychiatry—a psychiatrist's experience, do they expect a healthy person to walk up and to report [39] symptoms of a serious mental illness and to be distrustful of what is reported to them?

A There is a level of concern in the profession about that sort of thing, that is addressed to that kind of thing in training and so on. The whole issue of malingering, and which perhaps has been most acutely focused on in wartime situations of that sort where somebody might be malingering to get out of a very high hazard situation—Most people in the field have come to view that malingering is probably far less common than was earlier thought or even the average layman would be inclined to say.

Some of the things that we deal with, say the hysteria that we were speaking of before, there are still, I'm sure, many layman who would say that person is just faking. We are as a profession quite concerned about the

issue of malingering in insurance situations. There is psychological malingering as well as things like low back pain and other things that members of the medical profession see. So, there is concern about the issue of malingering. And, I would suppose that if somebody came along with some kind of odd symptoms that some place down the line they would begin to wonder, "Hey, is this person in an insurance situation or some other kind of situation where he's faking for a certain advantage?" But, that would be the framework from which I would think of somebody faking something.

[40]

Q If a patient, prospective patient presented himself to you with signs of a psychosis, what action might you take at that time?

A I would think if I were in a hospital context, if that were available to me, I might offer it as a possible alternative. I might at the same time suggest another possibility, suggest trying to work this out without leaving the home, community, job, whatever; try to work it out on an out-patient basis with the hospital as a reserved alternative that could be available at a later time.

Q But, you might offer some kind of treatment and then worry about malingering later on?

A Uh-huh (affirmative), with an adult I would typically, unless there's a major social risk and so on involved, I would leave it up to the person. Tell him what the alternatives were and leave it up to him and see which one he wanted to do. Use it to try to get a handle on what's going on.

Q One of the contentions that's been made in this case is that parents sometimes attempt to scapegoat

certain children in the family by labeling a particular child as mentally ill and everybody else in the family is healthy. In your experience is that a phenomenon that you've seen?

A I'll qualify the way you worded it by saying or taking out the words, "parents try to." Parents certainly do. Any social group, there's some risk of this happening. [41] When a group can't work out certain problems within the group, a group consensus develops that it's all so and so's fault. And, some hopefully wiser more objective outside observer might be able to say that's an inappropriate judgment on their part. And, that person did such and such kind of thing to focus attention on him; but this person over here was in the meantime subverting the group's effort. So, everything would be turned around; and they identified that as what was going on and recognized that that person was also causing trouble. Three other people in the group were causing trouble. This kind of thing does go on in families.

The alcoholic may be making very significant efforts to deal with this; but because of his alcoholism, they scapegoat him and blame him with everything else.

Q Or, it might be an adult member of the family, the husband or the wife?

A Yes.

Q Or, someone else?

A Yes.

Q In your experience how often does this occur?

A That's very very hard to answer. I can't put a percentage figure on it. There is probably some minimum of it in every group that interacts very extensively. When it

becomes significant, when it becomes an important factor in what's going on, when it becomes fixed on one person, it's[42] probably fairly common in terms of families in general of patients we see in child psychiatry; more common probably than in the average family. But, it is a part of what's going on.

Q Have you received training in how to determine the actual dynamics of the situation as by what the parents present to you?

A This is certainly a major part of psychiatric training, child psychiatric training is to try to do this. It can be exceedingly difficult. But, it's a part of what child psychiatric training is all about. It's how to look beyond what you're told, what's on the surface of the situation and try to see what's going on in subtler ways.

Q Would it be part of psychiatric training in general as opposed to child psychiatric training?

A Yes, again, this is a changing situation, because if you look back 25 years, psychiatric training was generally still considerably oriented toward the problem with the individual. Twenty-five years ago there was a very clear difference between psycho-analytically based training programs where people were being trained to look intensively and dynamically into family context and so on and non-analytically based programs which were looking much more for disease condition in the individuals. I think the dynamic perspective has spread to become essentially part of the ground work for [43] everybody in the field. And, people are going considerably beyond the psycho-dynamic/psycho-analytic perspective on dynamics and become much more aware of other social dynamics.

Q Would this—

A This is pretty much a normal part of training that everybody is taught to look at things in terms of the complex system of dynamics in which people function.

Q Would this also be true of other mental health professionals, psychologists, psychiatric social workers and nurses?

A Yes, it's sort of a standard part of the perspective.

Q How, say, in an interview situation or in a series of interviews do you deal with these problems, the problem of scapegoating, determining true family dynamics? What techniques in interviewing do you use?

A I hardly know how to put it in terms of technique. Theodor Reik who entitled one of his books Listening With a Third Ear, this is trying to be an independent observer of what goes on, trying to look at the totality of the context and see things that other people are overlooking, human communications. There is a good emphasis on paying attention to the words people say. But, there are many other indicators of what's going on in a situation.

If I'm seeing a family in a family group, then I have a chance to see not only what the mother is saying, but [44] the tricky little points at which father interrupts; and his choice of repetitive circumstances of the same context in which he interrupts may clue me to a significant dynamics of what's going on.

Seeing a patient individually—I recall one woman I was seeing one time. Just all kinds of explorations and inquiry led to no indication of any fluctuation of feelings about the things she was talking about. Everything was just sort of flat, this was it. I noticed, as I was talking, that

at times her leg muscles contracted in a way that the toe of the foot that was crossed over the other leg was pointed severely down; and at other times it was hanging relaxed. I drew this to her attention. She had been completely unaware of this as a thing that was going on. She couldn't explain.

Finally, I said, "Well, look, I'm going to guess that that's an indicator of tension and anxiety." And, I began to say every time I saw that toe go down, "What are you tense and anxious about?" And, gradually she began to be able to identify in herself other indicators of tension and anxiety. And, we began to be able to get them out. And, what you're trying to do is to look for just those sorts of subtle behavioral cues in a person in his own processes or in interaction with a group. To be able to identify things that are under current to what people are saying and what's [45] on the surface.

Q Have you visited all of the children and adolescent programs in the regional hospitals?

A Yes.

Q Have you visited the Children's Building at Central State Hospital?

A Yes.

Q In your opinion is the physical plant of the physical building at Central State similar to the physical plant at the other regional hospitals?

A It's quite similar to most of them. At this point the exception is Southwestern Regional Hospital which is using an old army hospital facility, and the physical layout is quite different. The quality of construction is very

different. It's quite a different plant. All the others are very much similar, modern cottage for 24 or 40 or so many patients; but with separate areas that can be divided up for different groups of children and adolescents and so on.

Q At Southwestern is there a separate children and adolescents building?

A There is a separate unit, separate building for children. At present they're operating a day program for adolescents who are housed in the general wards. It's a pattern they're using in the Atlanta Region and have not arrived at the point of having a separate building for adolescents.

[46]

Q Are you familiar with the treatment programs at the various hospitals for children and adolescents?

A To some degree. I've had a chance to participate in the staff meetings and interact with the staff at each of the hospitals and to get some sense of the treatment programs.

Q Are they fairly similar?

A There is some variability; some heavier use of behavior modification approach in some than in others. GMHI with the history of the association, with Emory and the psycho-analytic perspective, they've had a history of more of a long term expressive therapy. They all, I'm sure, are using some behavior modification. They all have quite well developed activity programs for children while they're in the hospital.

Q What about school?

A They all have school facilities and provide educa-

tional activities for the children while they're in the hospital.

Q Do the schools use specially trained teachers?

A Yes.

Q Are they hospital employees, or do you know?

A This varies. In some cases they are. Title I or Title V of the Education Act provides teachers who can be assigned from the education system to the hospital. When that's the case, they're paid 9 months a year from education [47] funds. But, because the hospital is a 12 months a year activity and the educational component is important year round, they're paid by mental health for the other three months. In some cases they are directly hospital employees.

Q Are you aware of any particular problems with parents not taking their children home when the staff of the hospital recommends discharge?

A I think this is probably a very occasional problem. This is most often the case with really quite seriously disturbed children. With a child who's schizophrenic, the parents may have a great deal of concern and apprehension about caring for the child as a memory of what happened earlier and so on. And, the hospital feels that it really would be in the child's best interest to be at home and to continue whatever is going on in a family and community context. The parents may still be unwilling to do that. But, other than extreme cases I'm certainly not aware of that being a problem. The natural parents would be willing to come and get the child at the time the hospital says it's appropriate. Parents are pretty used to doing what doctors tell them.

Q You've recently been working on developing a list of children who might need to be placed in specialized foster homes.

A Uh-huh (affirmative)

[48]

Q Would you explain please how that list was devised and what the reason for it was.

A Well, this is a concern that I had been aware of since I came to this position. There were some children around who hospitals were having great difficulties finding proper placement for. Hospitals have been largely dependent on Department of Family and Children's Services for making such arrangements. The legal conditions around providing child care facilities and so on are organized in that way. And, the hospitals have sometimes been quite frustrated in trying to work out an arrangement, feeling that they could do it themselves. But, they don't have the legal authority and so on.

With the many problems that have existed in the development of child and adolescent services, it's one I haven't put a great deal of effort into myself until recently. Now, over this past summer I have been involved in some activity that we're pointing in this direction. And, the Department of Social Services began to express some concerns this fall joined in with the other things that were going on.

We recently had an interdivisional committee that's prepared a series of recommendations including a significant expansion of these specialized foster care capabilities of the state to submit to Mr. Parham. In this context of this all this going on, the issues around this case brought

it [49] again to quite acute attention. And, the combination of these motivations, we put together a list. We asked each of the hospitals to report to us on the kids they had for whom they felt such a resource might be appropriate.

* * * * *

[54]

* * * * *

Q One of the essential contentions in this case is that there's a necessity of judicial or administrative hearing including a right to counsel and independent psychiatric exam, confrontation and cross examination of witnesses prior to the decision to hospitalize a child. In your opinion is there a necessity in each case for a judicial or administrative hearing with those attributes?

A I would think in many cases it would be quite disruptive. The child is already going through difficulty with his problem that he started with, and these are not good. If he needs to go in the hospital, that's certainly a change [55] from his normal life circumstances. That's true if he has to go into a hospital for tonsilitis or a mental hospital. It's another kind of thing and certainly has significant differences than a few days' stay in a general hospital for a medical condition. But, going to the hospital because you have something wrong with you is not that strange. Most kids as they grow up know and have found out that you go to a hospital because you have something wrong with you and consult with the doctor; and that seems to be the best thing to do. It's not that strange, I would say.

Due process proceedings in the court, witnesses and so on are much more alien in a child's life and airs all the dirty linen, not all of it probably, but it airs a significant amount of dirty linen in the child's life and parents' lives. And, all sorts of people sitting around passing judgment

on what's going on. And, it would be considerably more alien to the child's life than the somewhat familiar from the medical participation in dealing with problems.

Q If it became necessary for parents to apply to a court or to a hearing officer prior to the admission of children to the hospital and following the recommendation by the community program that the child needed hospitalization, do you believe that a number of parents would simply fail to file such a petition or request for hospitalization?

A I would think so, yes. There might be quite a number [56] of parents who would not want to get into that sort of a situation, but who would be able to work quite effectively with a hospitalization and return after a period of treatment and so on.

Q That's all the questions I have. Want a few minutes?
[Break]

CROSS EXAMINATION

BY MS. LINDBLOOM:

Q You mentioned before in your direct testimony that the community treatment centers, the community programs would determine whether hospitalization was appropriate and would make those recommendations to a regional hospital. Are there any written regulations or policies that you're aware of that speak to that or describe that?

A I believe so. They're not policies that say that that's absolute. Policies that say that's the preferred way of functioning. I don't think we would ever have policies that would say that's absolute. If it was clear that hospitalization was the need in the clinical judgment of

responsible physicians, then hospitalization would occur at that time. The procedure at that time would be to inform the community center that the hospitalization occurred to involve the community center with the parents or with the planning for the eventual disposition and so on.

Q Assuming—

[57]

A But, the admission might have occurred at the hospital without having gone through the community center.

Q Given that that situation might exist, is there any written guidelines, policies or regulations that speak to that, in other words, that you're aware of?

A I'm not certainly aware of any that do speak to that. I'd have to review hospital policies. I'd have to review division policy statements to check and see if that is specifically included.

Q You spoke of two general criteria that are used when hospitalization was appropriate. One was acute, severe degree of behavior. The second was social circumstances. Okay, assuming emergency situations, emergency admission would be appropriate, are there any other situations where acute—Can you think of any other situation where you mentioned an acute, severe behavior problem? In other words, can you think of anything else; did you mean anything else by that, anything that wouldn't be covered by an emergency admission?

A I made the distinction between emergency which would usually be within 24 hours or less for getting somebody into the hospital and severe behavior disturbance where an attempt might be made to manage it in some

alternative way. Then the decision is made to get them in. Where that stops being an emergency and becomes a social circumstance judgment, [58] it's a mixture of both probably, most of the time.

Q Okay, specifically when you talked about the social circumstances, your second criterion, you spoke about breaking of the vicious cycle that you described, that you described.

A Yes.

Q Again, in a non-emergency situation would there be any other alternatives to hospitalization in that instance? In other words, to break this cycle you spoke of.

A There could be, yes. You might try a foster placement.

Q Okay.

A I think probably in the present situation the hospital is a more expedient and quicker way to get the cycle broken and the child back into the home than going through the crisis of negotiating a foster place. There are some situations where there are emergency foster facilities where a child can be placed for a fairly brief time, overnight or up to a couple of weeks. And, this might be appropriately used at times. That would have to be, again, a clinical judgment as to whether just moving the child out of the existing situation with a relatively low level of other intervention, treatment and so on would be sufficient or whether you want to couple it with a fairly intensive treatment program.

[59]

Q How many of these emergency foster facilities you spoke of are available within the state?

A I don't offhand know. Clayton has quite well

developed emergency foster capabilities. There are some in other places. I don't know the details.

Q When you speak of the foster facilities, are those facilities that the local DFCS, the county DFCS office would have knowledge of and have recruited one as opposed to one specifically recruited by the Division of Mental Health, let's say?

A The ones I know most about are the ones in Clayton County—are described there as a protective services commission, police, court workers, social services, mental health; organizationally it's under DFCS.

Q You mentioned a training conference coming up in January.

A Uh-huh (affirmative).

Q Concerning the rights of children. Are there again any written policies or regulations now on the rights of children in terms of admissions or treatment in the state mental health facilities at present?

A No.

Q Okay.

A Except as they're included in hospital policy statements and so on.

[60]

Q Are there presently children hospitalized right now in the 8 regional hospitals in the state who hospital personnel in those specific hospitals indicate do not need to be institutionalized?

A Yes.

Q How many?

A We mentioned the 14 or 15 whom the hospital has judged to be in need of specialized foster placement. I

don't offhand know the number. It might be something approaching that number whom the hospital has judged needs residential treatment programs over a much longer period of time.

Q Do you regularly request that information about children in that position from the hospitals on a regular basis, systematic basis?

A We have not regularly requested it, because we have no capability of affecting the situation. I'm sure when we do have that capability, it will be a regular requested item of information from all of the hospitals.

* * * * *

[68]

* * * * *

Q Okay, again, going back to when you talked about adjustment reactions, you talked about it in terms of behavior, social behavior. Because of that, because of its being social behavior, would not the placing of the label of adjustment reaction be dependent on the mind of the labeler. In other words, whether the person who's placing the label, is going to place the label deems the behavior to be socially unacceptable or not.

A It certainly would have to be true, yes, that the person would agree that the intensity, the level, the extent of his behavior was socially unacceptable. What social unacceptability means; it means that the social group is not accepting; and that's why they brought them there in the first place.

Q Again, you were referring to, in discussing the importance of the diagnosis itself and correspondingly the treatment in terms of drugs that would be given, if there was a misdiagnosis and a wrong drug was given—Let's say an inappropriate drug was given on the basis of a

misdiagnosis, would there be an adverse effect on the patient?

A At the present state of the art most of the medications we use have a high level of—There is a high level of tolerance to these. The specific medication, the dosage and so on [69] is almost known by trial. Now, that's not entirely true. As I said before, a diagnosis of psychosis would make certain drugs the ones you try first. But, in specific cases a particular drug may have little or no beneficial effect. And, you're only going to know that by trying it.

We're not in the situations we are with anti-biotics where they can take a culture of the organism and test the drugs on a culture plate and see which one is most effective. The only way we have to test is to test in the person himself.

Q But, you can get an adverse reaction from using a drug that's inappropriate based on a misdiagnosis?

A No, I wouldn't buy that statement.

Q Okay, I just want to clarify what you were saying.

A There are adverse effects of such drugs. You run a risk any time you try a drug that has capabilities of producing significant effects. It may have adverse effects. For a person for whom it has beneficial effects, you're balancing out the adverse against the beneficial.

Q Are there any statewide policies or regulations, again basically within the Division of Mental Health, of which you are aware that speak to the separation of adolescents from adults in the 8 regional hospitals?

A There are no—

Q Are there any being developed at the present time?

A Not as policies. We're programmatically working in [70] that direction to achieve that.

Q Okay.

A We've only recently in the Atlanta Region been able to work things out so the staff—staffing and so on made it possible to provide 7 hours a day in which the adolescents are in an adolescent group with staff especially focused to work with adolescent problems. And, they return to the adult units for the remainder of the hours.

Q Then, you're familiar, I would assume based on your last statement, with the practice at Atlanta Regional that 12 year olds are considered adults; and they would be placed on adult wards?

A I don't think it's 12. I think the 12's are included in the children's group, if I'm correct. If I'm remembering right, it's not till 13 that they're moved.

Q Okay. Would you agree, in other words—

A Incidentally, I have stressed in my conduct with all the regional hospitals that I feel they should use these kinds of age limits flexibly and in functional terms. And, a 13 or 14 year old who is still very childish in many ways ought to be selected to be managed in the children's unit. And, only those who are in a more mature level of functioning should be treated as adolescents. That would be true if they had an adolescents' unit and children's unit.

Q Okay, are you familiar with the policy at Central [71] State Hospital where if the patient is under the age of 17 and if they are pregnant or have a child, they can be sent and placed in an adult ward? Are you familiar with that?

A I'm not familiar with this as a policy, no.

Q If you were developing regulations as to—You know, you said you were going at that; that was a basic future goal or objective. Would you include such a policy as a general guideline?

A I would want a functional judgment to be made again.

Q Okay.

A If the having of a child involved the young woman in a much more adult perspective on her own life in the circumstances, then I think she ought to be processed as an adult. If she is a very young 17 year old, immature, who has had a child or who is pregnant and is very childish in her whole response to it, then I think she ought to stay in the adolescent unit.

Q Are all the physicians who work with children and adolescents at the 8 regional hospitals within the state—are all those physicians certified child psychiatrists?

A No.

Q Are they all certified general psychiatrists?

A No.

Q Are you aware in terms of numbers the number of those physicians that are certified child psychiatrists and [72A] also speak to the number that might be certified general psychiatrists.

A There are very few who are certified child psychiatrists any place in this state in terms of Board certified.

Q Right.

A There are, I think, only several who are trained in child psychiatry in several of the institutions. Some of the institutions have eligible trained certified child psychia-

trists who are available on a consulting basis part of the time. But, one of the physicians effectively involved in the Columbus Region is a pediatrician, not primarily trained in psychiatry but trained in pediatrics and with a number of years' experience in psychiatry, child psychiatry.

We're seriously limited in terms of having anything like as many child psychiatrists as we would like to see in the regional hospitals.

Q You say, when you were speaking about scapegoating before, that sometimes it was difficult to see through to be able to understand the family situation to see if this was actually taking place. Would that be compounded then—in other words—that difficulty, would that be compounded by an admitting physician who would have problems understanding and speaking the English language?

A I'm sure it would.

Q Okay, again, you spoke that normally—

[73A]

A That is also a problem say with a northerner who comes down here and does not understand southern idioms.

Q Okay.

A That's part of what we have to work with.

Q You spoke also before about the fact that usually the natural parents of the child who had been admitted would take the child back in your experience, when the question was posed to you. But, you say that sometimes is not the case. Would you then say that parents can act

against the best interest of the child; that some parents can act against the best interest of their child?

A Yes.

Q Okay, is it—Assuming the natural parents of a child who have voluntarily admitted that child to an institution will not take him back, is it harmful for that child to be continued to remain hospitalized? In other words, assuming then the hospital personnel have stated that they feel he's no longer in need of that hospitalization.

A I'm sure, you know, a long persisting continuation in the hospital has some deleterious effects, yes.

Q Does your experience change—The question was asked you about whether or not natural parents take the child back when the hospital indicates to them that the child is ready to leave the institution. Is the same true with children who are in the Department of Family And Children's Services' [72B] custody?

A My impression is that the problem is considerably greater in that case. Natural parents, they have for the life of the child generally taken the position that that child is part of their family and they must deal with it. Foster parents would be more likely would be inclined to extend themselves to a degree for this foster child. But, they set a shorter limit on how far they go. There are some exceptions. There are some foster parents who are fantastic. But, I'd say on the average the child in DFCS's custody or foster placement who has these sorts of problems is more likely to be ejected from the family. Dumped on the mental system; dumped on the Human Resources System.

Q What would happen—Let's take a situation such as that. Let's say a local Department of Family and

Children's Services has voluntarily admitted a child; the hospital personnel involved with that child all conclude that he should be released from the hospital. What happens there? What procedures would happen? What would happen? Let's assume the hospital personnel have concluded that. What would happen?

A The basic step is the hospital personnel would contact the DFCS and say it's time for the child to leave the hospital. Get busy with it.

Q What if the Department of Family and Children's [73B] Services were unable to take the child right now?

A Then, it may be that there are further contacts, further efforts made; but the child stays in the hospital technically.

Q What efforts aside from what efforts the Department of Family and Children's Services might make after this point, after they've been notified—what further efforts would the hospital and/or the Division of Mental Health make for that child, if any?

A There have been efforts on the part of some of the regional hospitals staff to negotiate the DFCS so the hospital staff could seek out and recruit foster parents who would take these children and use the DFCS for the approvals and clearances. And, offers by the hospital staffs to provide continuing support, training supervision to these parents when they get the child. So far these efforts haven't been very successful. They have succeeded in some instances in getting some outside life for the child. I don't know of any that have created a lasting foster home as yet.

Q If I—

A The problem here in part is the history and tradition

of mental hospitals which have been dumping grounds in the past. As we try to move out of this, there are a lot of people who still treat them as dumping grounds. There are juvenile court judges who say, "I want this kid to be kept [74] in a hospital from here on out until he's grown." The DFCS takes the child to the hospital and says, "Now, it's off our hands." They're besieged with oversized case loads and so on to try and do things; and to take on the tough problem of a kid who's been through a period of hospitalization and is still not normal, back to regular who needs community living to get there, it's going to take some extra work. And, to take it on at a time when they're already carrying 70 or 80 normal foster cases is a huge requirement on them.

The community mental health programs have only been gradually been coming to the position of saying that the patient who is still in the hospital is still our patient. With a notion of the mental health center taking responsibility for all of the people in its catchman area and their mental health needs and having an on-going responsibility no matter where that person is, is a pretty new idea. And, they're only just gradually becoming involved in this.

A year and a half ago when I was here on a pre-employment visit, I heard a delightful story at Atlanta Regional. They said they've got one social worker out in the community program who keeps bugging them, saying, "When are you going to give me back my patient?" And, their reaction was, "Beaufiful, we've got one who's doing it. Now, let's keep it going. Let's get them all doing that."

Q But—

[75]

A This is only gradually happening in the total social process.

Q Specifically, going back to the hypothetical that I gave you.

A Uh-huh.

Q Assuming DFCS was the admitting person for the child and DFCS won't take the child back for one reason or another, assuming I'm the social worker in the hospital and the child is on my caseload, are there any regulations or policies that when I'm confronted with this situation would tell me what—specifically, what actions I might take, who else I might contact?

A I don't know of any policies or regulations. Atlanta Regional Children's Unit has worked out a practice where when a child of that sort is admitted, they enter into an agreement with the DFCS as to what their responsibilities are and what DFCS's continuing responsibilities are; and before the fact when the child comes to the hospital to set up the mechanism for getting the child out.

Q Those are policies?

A This is practice.

Q Practice at which hospital?

A Atlanta Regional I know specifically.

Q How about the other hospitals? Has this practice been adopted in other hospitals, the other 8 regional hospitals?

[76]

A I can't say that it is adopted with certainty. I don't know that kind of detail.

Q Okay.

A I believe this is operating at Augusta Regional in the children and adolescent program or something analogous to it. I'm not sure about all the others.

Q You mentioned—

A Another approach that is commonly used is for the hospital to contact the local mental health center and have them work with the DFCS to try to negotiate and work out a foster placement.

Q Is that written down, again? If I were a social worker, would I find that written down anywhere that that's a contact that I should make?

A I doubt it.

Q Okay.

A It may be, but I doubt it.

Q You spoke of a priority list that was developed this fall in terms of priority for specialized foster home placement.

A Un-huh.

Q When exactly, specifically, was that list—Can you give me in terms of a date or approximate date?

A A couple of weeks ago.

Q November?

[77]

A About two weeks ago.

Q November?

A Uh-huh (affirmative).

Q Okay. You mentioned also the two plaintiffs in this case, J.L. and J.R., were on that list. When were they placed on that list?

A At the time it was developed.

Q Again, two weeks ago?

A I requested this information from the hospital and put together the list. Both of those cases were on the list.

Q Okay. When you spoke of the 40 specialized foster homes, now are we speaking here about actual homes or are we talking about slot for homes?

A Slots.

Q Okay. How many actual specialized foster homes are within the state at present?

A I understand this is two children per home, 40 slots, 20 homes.

Q Okay.

A Probably with some of the kids you would place in those foster homes it would not be appropriate to put two children in.

Q Okay.

A So, we would probably have to operate at less than the 40 level, because we're limited to 20 homes.

[78]

Q Right.

A My understanding from the people in social services is that there are, I believe it's 15 or 16 homes currently operating and something in the neighborhood of 30 children placed in those homes. Those are approximate numbers.

Q In the letter of correspondence that you sent to the regional hospitals in order to form this priority list for specialized foster care, were they asked to indicate

the number of children—solely the number of children that needed specialized foster homes; or did they also indicate those children that were presently in their own hospitals that needed group homes? In other words, group homes as well as regular foster homes and the fa[illegible]y care foster homes? Was that information given to you?

A Earlier I had requested information on children needed specialized services, continuing services. And, I had some general statistics.

Q Uh-huh.

A Across the state on how many the hospitals felt needed residential treatment care, how many needed specialized foster homes. Some of them mentioned cases they felt could fit into regular foster home where a group home was appropriate.

Q Right.

A But, it was more or less the figures I've given you, 14 or 15 specialized foster homes, about that number; and almost [79] that number for residential treatment, and a few odd cases that would perhaps be manageable in other resources.

Q Other types?

A Yes. We've had a reasonable capability of getting kids into group homes, institutional foster care, places such as St. Joseph's Methodist Children's Home and so on. They have been pressed, as I understand it, because they used to take, you know, fairly normal kids who, because of family circumstances, didn't have a place to live. They're being pushed more and more to take troubled kids. And, they're having a great deal of difficulty with it. They're doing the best they can. But, they are taking

them. And, we have some fairly good working relationships with mutual support, hospital personnel providing support and assistance to them in doing this. They're having to work with the school systems, because a lot of these kids need behavior disorder classrooms in the school. When they got to those homes, they have to go to public school. So, there's pressure on the school systems to provide enough behavior disorder classrooms in Decatur to take care of the children from Methodist Children's Home, for instance.

Q Uh-huh. You mentioned in terms of recruitment of foster homes, I think you were specifically addressing specialized foster homes, that the local county system of recruitment, in other words, where the case worker, the local DFCS county case [80] worker was actually doing the recruitment, I believe you said, was unsatisfactory.

A I believe—

Q Could you elaborate on that?

A Well, particularly in the smaller counties of which there are a lot of them in this state.

Q Yes.

A Very small DFCS staff, they have to do a little of everything. They're not able to specialize. A particular social worker may be carrying a case load of 70 or 80 foster placements that she is supposed to be supervising; managing disbursement of welfare relief funds of various; looking after handicapped adults and others; and whatever the responsibilities are across the whole range of services. And, on top of that whatever is done to recruit new foster homes, because there's an inevitable turnover on people who are willing to do this sort of thing. Some people are willing to do it for a period of time and reach

another stage in their life and say, "I can't do it any more." So, it's—Those people are stretched very thin. To get a need for a specialized foster home, it is going to take more effort and so on, more time. It's a big imposition. Most of them have been recruited from people who have been doing foster home work who have shown what they've done, the interest, the care, the capability to deal with a more serious problem; [81] and then they make a transition from being a regular foster home and providing a specialized foster home.

* * * * *

[95]

* * * * *

Q Specifically—Let me ask you a specific question here. To your knowledge would a social worker who has like a child on her case load within the hospital, does she send, you know, regularly and on a systematic basis reports about that child to the DFCS office? Is that a written understanding? Is that an oral understanding that the hospital personnel will do that for a DFCS office that is concerned with that child's case?

A I don't think there's any written statement of this. I'm sure that 10 years or more ago it was standard practice that it was not done. The kid was there. That was it. They took care of him until they were ready to send him out, and then they tried to do something. Increasingly, the hospitals are actively soliciting on-going participation of DFCS personnel. When they have a child in the hospital, they are invited to come in for case reviews of their children. They're including them in the whole process as much as possible of evaluating how the child is progressing, when the circumstances [96] are going to be appropriate in trying to get, you know, the arrangements for placement established before the time comes for placement to occur. And, DFCS workers were regularly involved in case conferences.

Q Are you aware of, again, any obligation that's written down or any legal obligation that a local Department of Family and Children's Services county office would have to children who are patients in one of the 8 regional hospitals that are located within that county. In other words, is there any agreement, either written or oral understanding, that you're aware of for children who are patients there?

A I don't think the system is worked that way. I'm not sure quite what your question is. If a child comes from one county to the regional hospital, does the local DFCS have responsibility?

Q Right, I'm basically trying to find out if there's written down any kind of divisional guideline.

A I don't think there is any policy or intent that a county, say Baldwin County, would have responsibility with regard to all the children at Central Hospital. They would have responsibility only for Baldwin children.

Q Okay. Are you aware of any policy within the 8 regional hospitals to review particular child's, say juvenile's, child's or adolescent's case systematically? In other words, on a regular basis. I'm talking specifically now about his need— [97] to determine his need for hospitalization and alternative placement.

A Any of our hospitals that have standard hospital accreditation have requirements of that sort for the Commission on Accreditation of Hospitals. Any hospital aspiring to that will have to be in line with that when they do. We are actively encouraging, and as a divisional policy or a division code we have accreditation of hos-

pitals down as something to be achieved within the next few years.

Q Uh-huh.

A We actively encourage all the hospitals to have developed such policies. And, I believe all of them currently have some form of utilization review committee or some such procedure that's in their policy as on how all cases in the hospital will be checked at intervals after hospitalization.

Q But, this, in other words—

A The first interval being checking on the appropriateness of the hospitalization in the first place and its continuation. Then, at some fixed interval after that a recheck to be sure that the continuing hospitalization is still appropriate.

Q There would then be, in other words, there's a variation. In other words, each of the regional hospitals has their own way of dealing with that, their own way of dealing with review.

A Yes.

[98]

Q There's no, like, regulations statewide that they are required to follow in that respect?

A This is a place we haven't gotten to at the division level.

Q Okay.

A I'm sure it's a direction we're moving in.

Q Okay.

A We're trying to get things to that point where we

will have clear statewide policies. We're working through the process of getting there.

Q Okay. I'd like to turn now, going back to your direct testimony again, you talked about salaries and pay scales of professionals in private hospitals. Do you feel that the salaries that the state would offer let's say a psychiatrist or any mental health personnel to work in their facilities, that in comparison to what mental health personnel might get at a private facility might—

A Disincline them to take—

Q Thank you very much. That's just what I would have liked to have said.

A Yeah, I'm sure that if we could increase the pay scale, we could recruit more people to work within our system to some extent. This is like the situation of the academic psychiatrist who typically makes less than he could make on the outside. We are still relying, I think unduly, on a [99] person's dedication to a particular kind of job to get them there, rather than a salary scale. I'm making a hell of a lot less than I would be making in private practice and doing something that I consider much more exciting and am glad to be here. Wouldn't want to be in private practice. But, it would be nice to make something closer to what they're getting.

Q Okay. The next couple of questions I want to ask you, I want to make clear to you these questions are framed assuming these are non-emergency situations. We're not speaking here about a situation that would warrant emergency admission.

A Uh-huh (affirmative).

Q Do you believe that representation of a juvenile, or a child or an adolescent, at a pre-commitment, either

an administrative or judicial hearing, by having an attorney there who was speaking for his interests—again, in a non-emergency setting—would be harmful to his well-being or his interest?

A I'm not sure I understand the question.

Q Would you like for me to—

A I'm not sure how elaborate the process would be or if the juvenile is there, how long this takes, what goes on. If somebody went to the judge's chambers and said, "Hey, we got this kid out there that some of us think needs to be in the hospital;" and there was an attorney and the parents; and they discussed it, you know, that probably wouldn't [100] be harmful to the kid.

Q Okay, I think you'll understand more by my next few questions here.

A Okay.

Q You mentioned that in arriving at a decision, in other words, as a psychiatrist if a child or adolescent is in front of you and you're trying to make a decision on whether hospitalization is appropriate, you said in arriving at that decision you would want as complete and thorough a background information on that child as possible in order to make that decision. Is that a correct statement of what you said?

A I don't think so. It would be some situations where I could sit down with the parents and see the kid and in 20 minutes I could say, "I think hospitalization is going to be necessary. We'll get all that background information as we go along. We're going to need that in the total effort to help you and the child to work this thing out."

Q Uh-huh.

A But, it's obvious that hospitalization is needed now.

Q Given the fact that with certain people that you could not make a diagnosis fairly quickly, in general would it not be helpful as a general rule—would it not be helpful to get as complete and thorough a background as possible on the child?

[101]

A I agree with that.

Q Would not a hearing, an administrative hearing in which information would be brought out on both sides, information would be obtained from the school, let's say, as the child was in school as to his behavior?

A If it's a non-emergency situation we're—

Q Excuse me.

A If it's a non-emergency situation, we're going to ordinarily have time to get that. That's pretty routine to get that information.

Q Right. But, that would be information that you would want to have and that would be helpful?

A Yes.

Q Okay. If, again, when you mentioned the difficulty of being able to sit back and take a neutral view of seeing the dynamics of what exactly is happening within a family, above and beyond what is actually told to you by the parents or by the child, would—can you see a process such as a hearing being helpful in being able to collect more information that might be—that potentially would be important, that might be, let's say, embarrassing for the parents to admit. Now, specifically, I'm referring to, let's say, there was an incident of child abuse with the parents and the child. Would not it be helpful to have a hearing or a process similar to that in order that that information could come out?

[102]

A My only experience is that a great deal of information is going to come out through a long slow process and is only going to come out by establishing a relationship between the mental health professional and the child and parents and so on. It isn't going to come out in any hearing, no matter how many questions are thrown at people.

I've had many situations that I've dealt with myself with families where the really essential things for full understanding were things they couldn't conceptualize themselves at the beginning of the situation and couldn't have told you no matter how you cross examined them.

Q Let me clarify my question. I'm not envisioning—My previous question was based on the idea of at this hearing, be it administrative or judicial, that whoever was presiding would have access to information, let's say, concerning the report on child abuse or further information that would help in this situation as opposed to having legal counsel available who would grill the parent on the stand and this type of thing. Do you see what I mean?

A Supposing there was enough such information floating around where people could get at it—The kinds of things we have to deal with are so often things that aren't in that realm. I can't really imagine a more extensive information system, gathering system than we have now in dealing with families. We're using schools, using the family physician and [103] other resources, the family's reports and what not—which is going to be able to elicit information that can be presented within a couple of hours of hearing that's going to be of any significant help to me, except in very rare cases. Something might crop up that would go beyond what I would get in a normal evaluation process.

Q Would the admitting psychiatrists—again, speak to all of the 8 regional hospitals here—have the resources available, in other words, to track down this information? Let's talk about the school record of a child; speak about a teacher who might see him 8 hours a day—in other words, to supplement the information that they're getting from the parents.

A Of course, when you're talking about the hospital psychiatrist—

Q Right.

A You're probably talking about the emergency situation where the decision is not going to depend on getting all that information. That's going to come as a supplement. He could either get a release, write to the school for the information. He can contact the local mental health center, and this will help him much more. The local mental health center will go out and get that information and pass it on to the hospital even in an emergency admission case. If it's not an emergency admission and has been referred back from the hospital to the [104] community center or has come through the community center, they're in the position to get that information and do routinely.

Q Do admitting physicians in the hospitals have a series of written guidelines that dictate, again, set out information that should be gathered, in other words, before they make a decision; in other words, is this set out anywhere in a written policy? Again, assume I'm an admitting hospital psychologist, not an emergency; I appreciate your distinction for the emergency; but, in a non-emergency case that would dictate to me what actions I should take?

A I think probably I would assume all of the hospitals have some sort of standardized written-out statements as

to what goes into a basic work-up and so on. This is so much a part of one's professional education.

Q Sure.

A To know that what you do is to take a history, find out what the presenting problem is, evaluate the history of that, evaluate the social and family history of the person, find out about previous diseases, family indications of disorder, do a mental status examination, do a physical examination. This is standard practice.

Q Certainly.

A This is built into the training of the professional that this is the way you work. This is the way you do the job. And, I think that probably all the hospitals do have some [105] sort of, maybe not written as policy, but just the format that exists. These are the forms, you know. You fill these forms out. They have a policy on filling out forms on an emergency basis, what has to be filled out promptly after that before the first staff conference. Okay, we let this patient in. Here's the picture we have.

Q All right, I appreciate what you're saying, that an individual, specific individual, admitting psychiatrist in a hospital will draw on his professional background in order to make that decision. But, what you've said is you would assume that each hospital might or might not have policies that are written down that might help, in other words, that help that particular psychiatrist.

A I would assume that they all have some sort of procedure manual that sets out some kind of standards.

Q Right.

A On this.

Q That would be determined by each regional hospital?

A Yes.

Q As opposed to having like a statewide book.

A Right.

Q As a set of regulations.

A Yes.

Q Okay. One other point that you made—

A I am also sure that as we move ahead with the system [106] that the state office is going to be making periodic reviews of those and may come up with some policies, if it turns out that some hospitals aren't coming up with what we consider adequate standards.

Q You spoke of, again when questioned about the possibility of a hearing, the effect of a hearing of airing dirty linen. Might also there be another side to that in terms of clearing the air, if you will, rather than masking family difficulties or being therapeutic in that both sides of the story might be told?

A I would sure a lot rather do that in a more therapeutic environment than a hearing.

Q Okay.

A With bunches of people sitting around. I don't know how many people you're thinking of. Even 2 or 3 extra people will—the risk that there might be somebody over there behind that mirror looking would get in the way of people's being able to communicate. As back in the days when I was on the faculty of the medical school or a resident in psychiatry and took the medical student into an interview with me some time. This took very careful

work to clear the air on what right that person had to be there, what role they played and the confidentiality of what went on and so on in order to get people to be able to open up to things and talk about them. There was a marked discomfort.

[107]

Q You mentioned you thought a hearing might be disruptive. Wouldn't it also be a serious disruption in a child or an adolescent's life to be hospitalized?

A I think I've said that.

Q I just wanted again to confirm it.

A Yes. It's a serious disruption in a child's life to have a disorder.

Q Are children and adolescents, again speaking of what you're aware of in terms of statewide regulations or variations among each of the individual 8 regional hospitals, are they admitted under a specific time limit category, in other words, for a set period of time?

A I think in all cases, and the hospitals are now trying to make a particular statement, assuming after admission, as to how long they think the child will need to be in the hospital. As a generality, probably the programs we're able to offer in regional hospitals are most appropriate for kids to come in and stay not more than 3 to 6 months. To organize a program that can serve as a long term continuing useful service at the same time that is providing for a fairly reasonable rate of turnover to deal with the acute situations almost requires two different organizations. And, so in general I would say where we are at this point, 3 to 6 months might be the general range that we would aim to contain it within. There might be particular

cases where beyond that and [108] up to a year would be appropriate.

Q Are there any statewide either regulations or policies within individual or any of the 8 regional hospitals for informing children and adolescents of their rights as voluntary patients under the specific Georgia code sections?

A Yes, this is standard.

Q Could you describe—

A The—No, I can't describe in detail. Just before I arrived here, the Advocacy Section of the Division Office had to file a rights statement for adult mental health patients in the hospitals. And, this little booklet is available, and as I understand it, is routinely provided to patients when they come into the hospitals. It's available in all of the units and so on.

I think there has been some attempt to use this with children, and it's not written in children's language.

Q Okay.

A But, the staff are well aware of the issues involved and the rights.

Q Would a child—

A The rights booklet—are expected to inform children of their rights.

Q Orally inform them, you mean?

A Yes.

Q Okay.

[109]

A Now, those rights at this point include rights to have their clothing, rights to make telephone calls within

reason, correspondence, various and sundry things like that. For children at this point we don't include the right to leave the hospital until parents say so, until the hospital and parents agree. In that sense it's different from adults.

Q Specifically, concerning the right to discharge, in other words—

A Yes.

Q When a child—Would a child be told then what you explained to me that should his parents consent and the hospital also decides he should be released that he would be released? Is that approximately what he would be told?

A I couldn't say. I don't know that that is actually conveyed to any child in that specific detail.

Q Again, we're not talking about a written regulation; we're talking about an understanding of what your understanding of what would take place.

A I guess what would come closest to regulations is what's in the law on that.

Q I'd like t show you something. This is a notice to voluntary patients of rights to discharge. It's dated November the 4th, 1970; and it's to J.L., one of the main plaintiffs. It's Exhibit Number 3 to the stipulations of facts.

[110]

A Should I read all of it?

Q Well, I just wanted you to glance at it. The named plaintiff, one of the named plaintiff's in this case, J.L.; note there's a signature down at the bottom of that page.

A Uh-huh (affirmative).

Q By the name plaintiff. Do you feel—He was 7 years old at the time he wrote that. Do you feel he could understand that?

A No.

Q Okay. You mentioned the children's rights, in other words, a right to discharge would be conditioned on a consent of their parents.

A If a child is in the custody of the parents, yes.

Q Assuming that his discharge is conditioned on his parents' consent, and his parents don't want him and refuse to take him, what position is the hospital in at that time? And, again assume also the hospitalization is no longer required for this child, that that's the uniformed consensus of the hospital personnel that are directly involved. What would the hospital then do?

A I think probably the most appropriate thing the hospital would do would be to seek to have custody removed from the parents, if the parents are inflexible in their attitude that they're not going to take the child back. Probably also the hospital staff ought to be in some cases [111] sizing parents up and say it would be disruptive to send this child back to the parents in whatever we might be able to do during the time the child's been in the hospital, it might at times be appropriate for the hospital to raise the issue and initiate proceedings to have custody removed.

Q Specifically, what person in the hospital—Let's assume a situation like that existed, and you said that it would be appropriate for the hospital to check into having the parents' rights terminated, what person would be charged with that responsibility, in other words, to initiate action?

A I suppose it would be most likely the director; within a particular hospital they may choose to have somebody of a high administrative level take responsibility. The unit director might delegate it to a social worker or something of this order. I would think the director would probably be the focal person.

Q Would that unit director have any guidelines or memorandum directives that would speak to his role or the role of another person within that hospital structure that would say, "This is what you should do, you can do in this instance to initiate this, contact this person."

A I don't know of any guideline statements.

Q Is it your—Go ahead; excuse me.

A This is almost a new issue, because of the history of where the hospitals have been and so on. A conservative [112] view about disrupting family relationships which has been promoted by the courts and all sorts of people, mental health people have not been in the forefront of perhaps of coming out and saying, "We ought to break up families."

Q You mentioned the possibility in the future of developing guidelines for periodic review. You touched on that briefly before. Would you elaborate on that, in other words, what you anticipate.

A What I anticipate is that the division will—I think Doug Skelton has already sent out some requirements that the hospitals have periodic review practices and policies. I think probably—I think they all do. I'm sure at some point the division will be reviewing all such policies and exploring whether they seem sufficient, whether we need a general formulation from the state about such things.

I was involved, as I mentioned earlier, in the developing of a policy in confidentiality which has been blocked from being put into effect because the Department of Human Resources was behind us in developing a department policy in confidentiality; and they didn't want to have us put one out that would be out of line that would come out as a whole department policy. At some point in the near future I hope they may get clear enough on where they want to go that ours is going to go out as a department policy on confidentiality. It deals with it in some very broad general [113] terms, but has specific requirements that each hospital, each unit, each mental health center have its own policy and its own practices within these general guidelines for effectuating a confidentiality policy and seeing to it that all staff are informed adequately in training in regard to confidentiality. And, I'm sure we'll be doing similar things with utilization and review.

Q Is there anyone who acts specifically as an advocate for the rights of children and adolescents in state mental health facilities within the Division of Mental Health?

A We have an Advocacy Office that has responsibility to respond to any advocacy issues in regard to any patient.

Q In other words, their responsibilities go to the entire patient population.

A Yes.

Q How many people are within the advocacy unit that you mentioned?

A Three.

Q Is there any recourse or remedy for a child or adolescent who believes that he or she has been inappropriately committed? In other words, is there anything that

he would be informed of or any regulations, specific hospital or statewide regulations that you are aware of?

A The rights booklet.

Q The rights booklet.

[114]

A Which is not written in children's language and, therefore, hasn't been as useful in child and adolescent services as adult services. It includes the advocacy unit as a resource that any patient can call on. To the extent that the child is able to understand either the booklet or the verbal interpretation that's given to him, the child knows of the advocacy unit. He knows of his right to call on them.

Q At present are all diagnostic procedures conducted on an out-patient basis?

A No.

Q Okay, how—At present have you or your division ever recommended a change in the child and adolescent voluntary admission statute? In other words, any of your predecessors or are you aware of anyone else in the past within the Division of Mental Health who has made such a recommendation that there be a change in this particular statute?

A I'm not aware of any, no.

Q Are you aware of any reports by any dependent bodies or anyone within the division that address the issue of the appropriateness of a "voluntary" admissions statute for children and adolescents?

A The only group that I think might have done that would be the Child and Adolescence Study Commission which functioned, I think, in '73 or '74 for about 6 months

and [115] made quite a large number of recommendations. I don't recall a recommendation with regard to changing the statute being among the recommendations. But, it might have been. I can't say it wasn't.

Q Do you remember any of the report that you just referred to—Do you recall any of the recommendations that were made by that commission at that time, specifically, that stand out in your mind?

A In general I would recall several, I think. One that stands out clearly in my mind was there be no further development of the community system until a lot more study had been done, which struck me as the most asinine recommendation that I've ever heard of in my life. Here they were talking about improvements in the hospital system but blocking any further community program development—and completely ignored that recommendation.

Others were primarily focused in some cases in rather microscopic details about hospital services; that there be better work with parents of children in the hospital; that there be—I can't say I recall others in specific detail. I know I have reviewed it a couple of times since I started in this position. And, I've seen we've made considerable progress on a number of points. I haven't reviewed it—

Q Can you be specific about the progress that's been [116] made on the number of the points that they raised since the time the report came out, specifically with relation to the points in the recommendations?

A No, I can't.

Q Okay.

A We have significantly reduced the hospital—We

have higher staff-patient ratios, because of the less patients. We are providing much closer working between the hospital and the community system with a lot more continuing work with the parents of children who are in the hospital.

Q Okay, were you aware of any of the findings that that particular commission made in that report regarding the population, the patient population of children and adolescent units statewide?

A I have examined the report.

Q Are you familiar with their finding of the similarity in the types of behavior that led to hospitalization and state mental facilities with the types of behavior exhibited by youths who were involved with the juvenile court as juveniles, excuse me, as delinquents and status offenders?

A I am aware of that as a general consideration. To say that I remember it from the court, I can't say.

Q Were you—

A It's a truism that probably applies to most everywhere in the country.

[117]

Q Okay. Were you aware of the finding that that commission made as to the percentage of children and adolescents that were hospitalized that either had no family or a severely dysfunctional family or in state custody?

A I examined it. At the time I was aware of it.

Q Going back just for a moment to diagnosis. Is it possible for a psychiatrist to err in diagnosing a child or adolescent, in other words, in their concluding he was so seriously mentally ill as to warrant hospitalization or institutionalization. Is it possible?

A Yes.

Q Can the orientation and the training of a psychiatrist have any effect on his diagnosis to make the determination of mental illness?

A I'm sure it can, yes.

Q Are there different schools of thought as to mental illness concerning cause and cures which may strongly influence psychiatric judgment? In other words, is it possible that a psychiatrist would—Do you see what I mean?

A I'm not sure I see what you mean. There are different schools of thought that would lead some psychiatrists to say the only way we're doing any good is if we do it on a very long term intensive treatment and to reject and derogate any treatment that doesn't fit that pattern.

There are other schools of thought that would say [118] the reverse. There are other ways that are important.

Q That's what I was getting to. Can the context of a psychiatric evaluation have an effect on the diagnosis? In other words, if the diagnosis was being made let's say in a community treatment clinic as opposed to right within the hospital itself, can that have an effect?

A Yes, I'm sure it can have some effect. I think since most diagnosis is based—Well, the diagnosis is not finally assigned until a significant amount of time has gone by and a fairly complete evaluation is made. You may make a preliminary diagnosis.

Q Uh-huh.

A And, that might be conditioned by the circumstances under which it's made. But, within a particular school of thought when an adequate evaluation is done, I

doubt that it would make—well, a fairly small amount of difference.

Q Does a single unstandardized interview by a psychiatrist—the results of which assuming a psychological testing supplements—present an adequate sample of this person, of his possible potential patient's behavior?

A In some cases it can be an adequate sample for at least initial decisions. You're asking a question that is just as applicable in general medicine.

Q Okay.

A When you take a history; you do a physical exam; [119] you do preliminary lab tests. All that may indicate is that the person needs to be in a hospital for much more extensive testing.

Q Okay. Is it possible that a psychiatric judgment may be influenced by the socio-economic background of both the doctor and the patient, the doctor's value system, personal preferences, these types of things? Is it possible that they would influence a decision?

A There are some good studies in the past that have pointed very clearly in that direction. There have been some more recent challenges, recent questions as to how true it is. I think it's possible, yes.

Q Based on the questions and the answers you have given to these last few questions, considering the factors that we've discussed that might influence particular doctors, isn't it possible that doctors could disagree on, for instance, the severity of a mental illness or the label of a mental illness that would warrant hospitalization?

A Yes.

* * * * *

[1]

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

Deposition of DOCTOR LUCIANO L'ABATE, taken on the 15th day of December, 1975, in the offices of Georgia Legal Services Programs, 15 Peachtree Street, N.E., Atlanta, Georgia, before Jean M. Wall, Court Reporter T-24, 1521 Mercer Way, Decatur, Georgia

---

APPEARANCES:

For the Plaintiffs: DAVID GOREN, ESQ.
Georgia Legal Services Programs
Macon Regional Office
653 Second Street
Macon, Georgia 31201

For the Defendants: DOROTHY Y. KIRKLEY, ESQ.
Assistant Attorney General
Department of Law
132 Judicial Building
Atlanta, Georgia 30334

[2]

MR. GOREN: The stipulations are all formalities are waived and objections are reserved until the time of trial.

MS. KIRKLEY: Except as to the form of the question and the responsiveness of the answer.

NOTE: (The witness was advised of his right to read and sign his deposition, and he specifically waived that right.)

DOCTOR LUCIANO L'ABATE, HAVING BEEN DULY SWORN AS A WITNESS, TESTIFIED AS FOLLOWS:

EXAMINATION BY MR. GOREN:

Q Please state your name and address?

A My name is Luciano L'Abate and I live at 2079 Deborah Drive, Atlanta, Georgia 30345.

NOTE: (Plaintiff's Exhibit Number One was marked for purposes of identification.)

Q Can you identify Plaintiff's Exhibit Number One?

A This is my curriculum vitae.

Q What is your profession?

A I am a teacher.

Q And could you describe for us essentially—excuse me, what do you teach?

A I teach psychology in the Department of Psychology at Georgia State University. I'm also Director of the Child Development Laboratory in The Family Study Center, and I'm Director of the Family Study Program — the Ph.D. Family Study Program in the [3] Psychology Department of Georgia State University.

Q Okay. Are you also in private practice?

A Yes, I'm also in private practice . . . and I practice mostly of marital and family therapy.

Q What is your educational experience?

A I have a Ph.D. from Duke University and a Post-Doctoral Fellowship with USPHS—United States Public Health Service, at Michael Reese Hospital, Psychiatric and Psychosomatic Institute. I have been essentially working in a hospital—in hospital-like places since I was graduated from college—from Tabor College in 1950. I worked for a whole summer as an attendant in Canadian Psychiatric Hospital. Then during my work toward a Masters Degree at the University of Wichita, Wichita State University, I worked as an attendant in a psychiatric ward of a general hospital, Wesley Hospital; and since then I've been associated with Duke University School of Medicine, Michael Reese Hospital, Washington University School of Medicine, Bernard Hospital, which is the psychiatric hospital. From 1959 through 1964 I was consultant to St. Louis State Hospital, which is a state psychiatric hospital in Missouri. I was Chief Psychologist, Department of Psychiatry at Emory from 1964 to 1965. From 1965 through 1973 I was Director of the Psychology Laboratory in the Department of Pediatrics at Emory University School of Medicine. I've been in my present position at Professor of Psychology at Georgia State since 1965.

Q Okay.

A In 1965, and since then, I've been consultant to Alto Juvenile [4] —Juvenile Institution for First Offenders, I've been consultant to various school systems, various private schools, and hospitals, and I'm presently on the current staff of Tucker's Doctors Hospital.

Q Have you had any publications or articles?

A Yes, I've had a few publications, and they are in this list here.

Q In your vitae?

A Yes.

Q Have you had any articles published specifically referring to children?

A Approximately fifty percent of my articles deal with children. In the last few years, I've had fifteen, twenty publications dealing with children and the family mostly. I've recently published a book, Teaching the Exceptional Child, which is a standard textbook in colleges in the United States.

Q Okay. In your experience have you ever been called upon to observe and evaluate a child's behavior in regard to his or her parent's request for help and possible hospitalization?

A Hundreds of times, and in my practice I've evaluated upward of approximately five thousand children.

Q Is it your experience that problems which lead parents to seek hospitalization of their children can be traced to family difficulties and not just the illness of the child?

A Well, it depends on the nature of the illness. If you're talking about a severe organic problem or in terms of extreme retardation, in some cases I—especially if it's clear that the child not only detracts from the family's function and ability [5] as to the stress, clearly that might, in some cases, be relevant of hospitalization. Outside of these very extreme conditions, I don't consider hospitalization as a viable alternative.

Q You think that family difficulties have something to do with these other problems with the children?

A Well, one way or another, all of us live in a context, and to deny that context, which is the family, I think, is a grievious, theoretical, emperical, clinical mistake.

Q What types of dynamics exist which could contribute to psychiatric problems of children?

A As I see it, in terms of what the outcome I've seen, in the kinds of cases that I've studied over the years, seem to be based on the parents inability to deal with their own selves, and their own marriage, so that they—either inadequate or the relationship between themselves, which is their marriage, makes it very difficult to deal with a child, and if they do deal with a child, they deal in inappropriate ways, mostly negative, it will eventually produce negative behavior on the child, because that's all he has learned.

Q Are you familiar with the term scapegoating?

A Yes.

Q In what way, if any, do you see that or any other types of interactions relevant to a child's psychiatric problems?

A Well, I see scapegoating as based on mechanism which I personally call externalization, which I think has experimentally been found in a work of a social psychologist, especially I refer to the work of Duval and Wicklund, which published in 1972, and they were able to find two different kinds of awareness. One [6] they called subjective awareness, the other one they called objective awareness, and they discovered that fairly well consistently people see two different—these two kinds of awarenesses. The objectively aware individuals are able to see themselves as part of any kind of interaction. The subjectively aware individuals are individuals who cannot seem to realize the impact on others. And their work pretty well would seem to agree with hundreds of studies done by a fellow called Witkin, which divides individuals between feel dependent and feel independent, and the work of another psychologist called Rotter, who talks

about internalizers and externalizers. And essentially they seem to be talking about the fact that there are individuals who really are externalized in most of their perceptions, most of their behavior on outside sources and outside targets, so my general feeling, which is—theoretically, I think, can be empirically demonstrated. Most of the parents of children who have problems are individuals who will fall in the category of subjective awareness. They don't seem to have an awareness that they have an impact on a child, the child's behavior or pathology is in someway related to their own pathology.

Q When you're going to evaluate a child's mental condition, who is the primary source of information on the child?

A Well, let me think—I think that's an important question. Let me answer in terms of the fact that for twenty years I did just that, evaluated children, and evaluated hundreds and thousands of children as a child clinical psychologist. My awareness, in working with children and doing therapy with them [7] as individuals, and by-passing the family, and not obtaining results, got so extreme that I finally quit doing what I was traditionally doing; that is, evaluate a child and then report the results to the parents, because I found that I was part of what I would call a collusion, the collusion that the parents had in making the child the scapegoat, making him what is called the identified patient. And before I was agreeing with them by evaluating him as a patient, I was agreeing with them in that he was the problem. Since 1972 I have pretty well quit evaluating single children, and I only will evaluate the child with the family, and if the family is not willing to come in as a whole family, that is children, siblings, and so forth, I will not see that child. So I have

drastically revised my practice. This is why from child clinical psychology practice I am now working mostly with the family or the parents. That is why I am a marriage and family practitioner.

Q Who is the primary source of information about the child when you are going to work with the family?

A Mostly the mother, is mostly the major source of information.

Q In getting these principles of subjective awareness that you described for us, could those circumstances cause a mother, or both parents, to mask their true feelings and distort or misperceive facts concerning their child?

A Very much so. I don't only think just the parents do this, I think there is plenty of research to indicate that many people who are interviewed, including schizophrenics, will very much depend, because of the feel dependent orientation of people who seem to be more vulnerable to mental illness, that they [8] will look at cues into the interviewer, and they will try to fit and please the cues the interviewer gives, and I suggest the work of the Braginskys — Braginsky, Braginsky and Wren, 1969, that indicate that's a process that goes — that is present in many interviews; that is in many cases the clients want to appear sicker than they really are, especially at first blush, which is usually the first interview. So there seems to be assets, for many people, and the parents of children who have problems do not differ in terms of wanting to make the child sicker in some cases than he is.

Q Okay. In trying to ascertain what is really going on in a family situation, given these problems that you've just described, is it difficult for mental health professionals

to try to understand exactly what the true facts are in a given situation?

A Yes, it is difficult. In some cases it takes years, to work with the family, to get all of the information. This is with most cases, treatment consists of finding—I would not call facts, but all of the various relevant skeletons that there are in a closet in which many families keep very, very close locked door on.

Q Would these difficulties be increased if the person who is doing the evaluating had difficulty with the language of the—say the child, or the family, that the person evaluating—or was not familiar with the cultural background of the person that he's evaluating?

A Well, all I can think about is my experience, and I know that I clearly see a certain kind of families, and I'm more successful with some of them than others, and I would presume if they are [9] middle class American Protestant, as an Italian Protestant, I would say I have much better luck working with them, than, I'd say, if it were some other kind, so clearly there is a great deal of research to indicate that the closer the similarity between the therapist and the client, that the better the chances of therapeutic success. So there is a similarity factor in there too, which indicates that I would be very unsuited, and I'm sure I am, to work with certain kinds of families.

Q Okay. In your experience, have you found that it is possible—that there will be occasions, when, for the best interest of the child, he or she will have to be removed from the home?

A If four or five different other kinds of things fail. In other words, I see the removal from the home for whatever reasons, whether it's foster home or hospital, as being the result of extreme failures of trying other methods, and we do have at this point, a significant technology of a variety of procedures that can be worked out, so I found, really, no excuse to jump from a child in a home to away from the home, unless four or five different possibilities have been explored, and there are many of them.

Q Are you saying that these possibilities ought to be explored before hospitalization?

A Definitely. Definitely.

Q What kinds of possibilities?

A Well, first of all, the reports from teachers working in the school, the classroom with the parents learning how to manage the child, behavior modification procedure, to train them to use positive rather than punitive approaches, structural methods [10] of dealing, of enrichment of methods that we have developed to work with families, of classes for the parents to take with other parents, like P.T. There is a tremendous amount of preventive approaches that are available these days, that parents can be and should be in a way forced to take if the alternative is clearly, you know, take the child away. Before you do this, the parents should be forced, in a way, to partake and learn more about what it takes to be parents.

Q Suppose there is a situation where those types of things have been attempted, is then the next alternative hospitalization?

A It would be very difficult. It would depend on what alternatives, with whom and so forth. It could be, but it seems to the hospitalization, in terms of the work of Skeels, it's really, to me, like a sentence of death. I think Skeels' work clearly indicates, in his follow-up of children who were hospitalized and children who were not

hospitalized, very clearly indicated, that if we hospitalize infants or children, the outcome is going to be really, diliterious, and that it's better, let's say, to put children in foster homes. So for instance, if you had another choice in terms of taking a child away, well, then, it would be that the child would be in a foster home, and hospitalization be, let's say, the outcome of failures in fostering, in taking care of the child, or even halfway houses or cluster homes. We know that the whole State of Tennessee, for instance, has been able to do away with hospitalization through the model of what they call the—the rehab model, so that that work, I think, is important [11] to indicate that hospitalization should only be the result of failure in a variety of alternatives, that we have in many, many cases failed to explore and use to the fullest extent.

NOTE #300

Q Okay. Do you believe that because of problems that may be within the family itself, the parents can at times act against the best interest of their children in seeking their hospitalization.

A Oh, I think there's enough literature to support that. If we all take the literature on the battered child syndrome we realize that, first of all, it does happen, and secondly, that of course unfortunately many of the battering parents were battered children themselves, and I think there is pretty much that kind of vicious circle involved in—in many parents have been unable to become full-fledged parents and know how to parent, because they did not have any better parenting themselves.

Q Is it also possible that parents may seek to hospitalize their children, and that that hospitalization would be against their best interest?

A The parents? It seems to me it's evident, because first of all, my accepting a child in the hospital or taking

the child away, we are agreeing that that child is a patient. Well, by doing this and agreeing with the family, we're essentially colluding with the family, and we are agreeing with them that if the child's behavior changes, the family will be okay. Well, to me that is the position that is logically and emperically impossible, because, what we're really saying is, if the child is a product of a system, which is the family system, then the whole system [12] has to change together with that child. However, if we take the child away then we're also agreeing that the system will not change. And this is what I've seen for twenty years, and this is why I finally gave up my practice of dealing with the child. When I took the child in treatment, the rest of the family said we're okay, they took that communication to represent that we're okay. When I confronted the rest of the family, "Hey, this family has to change," the . . . says, "Now wait a minute, he has to change, we don't have to." And so hospitalization without attention to the family, is a red herring. It's a . . . We agree—we agree with the family that the child is the patient, is the problem and that they should not be considered.

Q Okay. Do you have an opinion in regards to whether or not mental health professionals can make errors in recommending hospitalization of children?

A In terms of emperical data—in terms of the specific problem of hospitalization versus non-hospitalization, I don't know that we have data to support it. I do know that we have hundreds of papers of a hundred diagnostic witnesses we have in our every day life, so I am perfectly aware of the fallibility of our diagnostic labels, our own diagnostic tests, and in many cases our tests that we use in clinical psychology are not better than the criteria we

use, which are mostly psychiatric diagnosis, and realize that any time we have that kind of criteria in our tests they are really not very good.

Q Are there any tendencies that may be inherent in screening done [13] by mental health professionals which, for instance, may cause them to over-diagnose mental illness?

A That is definitely one of the major aspects, especially in psychological reports, many content analysis is made of psychological reports indicate that we tend to over-emphasize liabilities and limit the assets.

Q Were you present at Daniel Offer's deposition?

A Yes.

Q And are you also familiar with his work of the Psychological World of the Teenager?

A Yes, I reviewed it in General Personality Assessment, 1970.

Q What is your opinion of his statements in that book and his testimony in regards to the voluntary commitment of children in mental hospitals?

A I'm sorry, but I really fail to see the significance of that work in terms of the issue of hospitalization. His sample was drawn from what I would consider forty-eight percent or fifty percent of the population, that was the middle class population. That means that any of these figures that are present in this book, have to be halved—cut in half, to have any kind of statistical significance, so that if he says there are three types of adolescents, well, first of all he eliminated out of his sample twenty-three percent of the adolescents that would have troubles. Well they were not part of his book. Well, these are the kinds of adolescents that indeed would have trouble and would

come up for some kind of psychiatric or mental health evaluation. The other three [14] kinds of adolescents that he describes, the continuous growth, surgent and tumultuous growth, which have twenty-one and thirty-five, I think, and twenty-one percentage of his sample, in terms of the fact that he took a sample from fifty percent of the population clearly indicates that any kind of generalizations can be made from those samples as to half of the total sample. In other words, any kind of conclusion he makes in terms of the general population, would have to be—if you take—if you total that up you get seventy-seven. Well, actually half of that would represent any kind of generalization for the general population. Furthermore, it would not address itself to minority groups except—it says fifteen percent for his sample. But lower class was eliminated, upper class was eliminated, so there are a variety—well, it's clearly urban sample, so despite all the problems of mental health of the adolescent, that book, in my personal opinion, seems to be irrelevant to the issues.

Q Are you saying he also found that twenty-one percent of the group that he studied exhibited adolescent turmoil?

A Yes, in fact he did consider that the tumultuous group, which is his third group, which had tremendous ups and downs, also had twice as much counseling and psychiatric referrals as the next group, which was the surgent, which was the major thirty-five percent, with the continuous grow group of twenty-one almost have no referrals whatsoever.

Q And in spite of this high and low swings that he described for this group, he still considered these boys to be normal, is that correct?

[15]

A Yes, indeed. Yes.

Q Do you believe a hearing prior to commitment is necessary for the non-emergency admission of a child to a mental hospital?

A I think it would be helpful. It would be certainly, at this point, as things are, imperative.

Q Why is that?

A Because I feel that as things are, the best interest of the child lie in due process, and if there is no due process, that is if there's no attention to the child's rights, I don't think that even the mental health profession are aware of what these rights are, and in many cases due process is not really followed. In some cases attention may not be given to distortions in the parents, possible biases in the mental health personnel, especially as if they have an investment in filling the hospital beds. If state allocations are made on a basis of how many patients are there, or how many criminals are, then we're dealing with a system which has an investment in numbers of people admitted, and I as a teacher, have an investment in people coming to Georgia State, because if there were not enough students, I would not have a job. So it seems to me that people who are in hospitals, and work in hospitals, have an investment in having patients, and that in itself, is to me a fact that speaks for itself.

Q How do you think a hearing could be beneficial for a child?

A Well, first of all there would be safeguards of complete evaluation. If we're talking about a successive . . . kind of approach that is various alternatives, then you have all the [16] information of people who have been

involved with the family, let's say a study of the family, of the home situation, a history. There would be a variety of mental health professionals, not just one or two single ones. There would be different professions present. There would be the history of the attempts to deal with that child and the family with all of the possible failures, so that we would make sure that various alternatives and various . . . be present, and the people who have participated throughout the process be there to address to the issue of hospitalization. So that at this point, then, the hearing would guarantee that a variety of viewpoints be heard, which in a way would correct the children, so that there is the guarantee of checks and balances which at this point, as far as I know, is absent.

Q Is it necessary for a child to have an advocate?

A I think it would be extremely important. I'd like to bring to the attention the book on Child Clinical Psychology by Williams and Gordan which I have reviewed recently, I think it is still to come out of the press, in which this viewpoint of advocacy for the child is very strongly emphasized by most of the authors in that book.

Q Do you think that, for instance, personnel who work for a state mental hospital or who work in a state mental health clinic, could act as advocates for the child? Or would it have to be someone outside that system?

A Oh, I would say they should have somebody outside, because [17] clearly we are as limited aspects of our own profession as any profession is, and I would certainly feel much more comfortable if the legal aspects, the rights of a child, be safeguarded by a non-mental health professional.

Q Okay. Do you think that even if a child is deter-

mined to be in need of hospitalization, that it's necessary to have a periodic review by one independent of the hospital?

A Well, this, I think, would be part of the process, if there is an advocate which is not mental health oriented, then he would not only be objective, but he also would make sure there would be a periodic review. I think that this is one of the frightening aspects of hospitalization, that once the child is put behind doors, he is forgotten, and is forgiven, and that trauma at that point is really followed by the trauma that perhaps nobody else will care for him, and no matter how therapeutic the hospital may be, some link to the outside world still would be very important to have.

Q Have you had—I believe you mentioned you worked at Alto, is that right?

A Yes.

Q And therefore you are familiar with the behavior of persons who have been labeled juvenile delinquents?

A Yes. I also worked as a consultant to Coweta County public schools where I was given to work with the most serious offendant in the system—the school system, in addition to Alto. (sic)

Q Okay. And have you been made aware of any situations where parents [18] filed petitions in juvenile court to get help for their children whom they consider unruly or incorrigible?

A I'm aware there must be some kind or process. Actually, I'm more aware of the fact that the parents will let go many situations until the child is in so much trouble that he himself will call attention to the problem. To me

that is the—most—most of the process is done by omission rather than the parents themselves committing the child. They'll let the problem go until the child gets in trouble.

Q Have you been able to compare the behaviors of persons who are labeled juvenile delinquents with the behavior of persons or children who are labeled mentally ill?

A The only thing that I see that kind of behavior, is that the mental illness manifested itself in criminal behavior. In some kind of social strata that will bring attention to the police. In the middle upper class youngsters I've seen and I still see in my private practice, there is some protection in a sense that if the police picks up the son of a middle class white child, they will probably try to protect that child in many more ways that just putting him into the legal procedure of declaring that child a criminal.

Q Do you see any similarities between the types of behaviors that lead one to be labeled mental delinquent and one labeled mentally ill?

A Anytime I examine, and I've examined, I forgot how many juveniles at Alto, everytime I examined them, if I had been blind to the fact that they were in an institution, I would have probably agreed to put on them some kind of a psychiatric diagnosis.

[19]

Q So there are similar behaviors?

A Well, if they are not similar, there is a tremendous overlap.

Q I have no further questions.

EXAMINATION BY MS. KIRKLEY:

Q Are you a consultant at Alto?

A I was for a year.

Q Alto is not for juvenile delinquents, is it? Isn't it for youthful criminal offenders?

A Yes.

Q Sentenced by the Superior Court . . .

A Yes.

Q . . . rather than juvenile delinquents sentenced by the Juvenile Court?

A I am not familiar with all these aspects, but I know they were criminals, yes.

Q Okay. I think as you reviewed your private practice in the last few years, perhaps since 1972 explicitly, you said that you had started to look at a child in the context of his whole family and to threat the family rather than just one individual member of it?

A Uh-huh. (Affirmative.)

Q Do you have any evidence that the Georgia Public Mental Health System treats the problems of children any differently than you do?

A The only knowledge I have is that most of the—that some of the system in some cases, follow the tradition of team approach, in which you have a psychiatrist, a social worker, [20] and a clinical psychologist in which the child is evaluated, and then a history is obtained from the parents and so forth, so that although I'm aware that in some mental health clinics, the families are being seen, and the identified patient is seen together with the

family, I'm also aware that many of these practices vary from clinic to clinic and from individual to individual. That's the best I can tell you.

Q But you are familiar with the practice in some clinics that try to treat the family?

A Oh, yes, definitely. There is some of it. I'm aware of the fact that at least at G.M.H.I., they still will—in the children's ward, which I visited as recently as six months ago—they still will accept a child individually and not require treatment of the rest of the family, so that, again, they will—they will accept the child but not force—you know, make sure that the family does get treatment too.

Q But do you know that G.M.H.I. has a policy of not accepting the child for non-emergency admission unless there has already been treatment of the family in a community mental health center?

A No, I'm not aware of this.

Q So you are only familiar with respect to the hospital admission decision, is what you're saying?

A Right. Well, what I've seen as I visited and what I asked.

Q What about emergency admissions? Do you see some situations in which children need to be admitted because they're suicidal, for example, and then you would treat the family later?

[21]

A I have not seen many suicidal children, so I really can't say that there was a kind of emergency that I would deal through hospitalization.

Q But you can conceive of situations in which children are so suicidal that that would be a treatment of choice?

A I can't say. I have not seen it. I would probably, before getting that kind of step, I would probably ask the help of some other professional, I would ask a psychiatric consultant to see whether we could use some other medicines or drugs, which I—you know, I don't . . .

Q Isn't suicide a leading cause of death in children and adolescents?

A It's certainly getting to be one of the high reasons for it, yes. We have some of it. In whatever it seems to be the possibility of suicides, and there are very few cases I've seen, it's the ultimate results of a child's helplessness in controlling the family, so I feel that in the midst of the—what seems to be the reasons for the suicide, the child—this is the child's ultimate weapon, to blackmail the family. Suicide in many cases, at least as I see it, is a form of blackmail. It's a very deadly form of blackmail, and many adolescents will use threats of suicide, rather that the actual suicide. Naturally, no family, on the basis of threats is going to not do anything. They're going to try to deal with it, but in some cases, and I can't speak because I haven't seen it that many, I prefer to still deal and take the danger of the possibility rather than going through the hospitalization. In some cases I dealt with suicide with adults, and my answer to that kind of threat is to call the police.

* * * * *

[38]

* * * * *

Q Are you familiar with the drop in the patient population in Georgia's regional hospitals since 1964?

A I am very aware of the drop at Central State Hospital since I have visited that hospital once a year for the last ten years as teacher of my exceptional child class, and so that teaching those classes I wanted my students to become very aware of the—you know, what happened to our children, so I have regularly visited Central State Hospital. My last visit, however, was not in terms of that kind of teaching. I was there as a member of the board and Vice President of Georgia Psychological Association, so nonetheless, I certainly have been very pleased by the changes that have occurred at Central State Hospital, and I hope there are going to be much more, many improvements made. There are many to be made yet.

Q From this yearly examination of Central State Hospital, then, do you have any evidence in Georgia that supports your statement that the budget is allocated on the basis of the number of patients?

A Well, what you do is, if the budget is not allocated on the basis of beds, it's still made on the basis of outpatient clinic treatments, so I would hope that if they—if instead of going to beds, I would hope that the money goes into treating people outside.

[39]

Q All right. But you stated that one reason why psychiatrists might admit to the hospital, was you hypothesized that it might be so that he could still receive his same budget.

A I did not say psychiatrists. I will not judge—make—I talked about mental health personnel. If you would like to go back to the tape. I hope you realize I talked about mental health personnel.

Q Well, don't you know, Doctor, that in Georgia's

regional hospitals only a psychiatrist can make the decision to admit?

A Well, fine, but I'm not going to judge psychiatrists. I don't want to speak about psychiatrists. I think psychologists have as many errors to look at as psychiatrists, so I will not pass judgment on that particular—another profession.

Q Well, do you have any evidence in Georgia to indicate that any mental health personnel is over-diagnosing in order to increase their budget in a hospital?

A Well, in terms of evidence?

Q Uh-huh. (Affirmative.)

A No, I have no evidence. I do have the fact that if —if you look at the hospital beds, what has happened is that any kind of subtractions in beds and people hospitalized in Central State Hospital, as a result they have been sent in the other regional hospitals, so the total number of beds, very likely, has stayed either constant over the state, it's just been spread out. I would presume that if you count all the beds in the various regional hospitals, you are probably going to have the same count there used to be a Central State Hospital when it was [40] the only receiving hospital in the whole state.

Q But you have no evidence that Central State has tried to keep people there?

A No, I wouldn't—I wouldn't talk about that in terms of evidence. I'm talking about the fact that if you have two counts—if you have people—if you have people, you know, who are out working in hospitals as against people that work outside of hospitals, you're going to have two different kinds of viewpoints, people who work in the hospital will probably subscribe to a view that it's necessary to hospitalize people. People outside will view a less custodial and less oriented towards hospitalization. I think that work was supported by one of Offer's coworkers, Doctor . . . who has done the work on ideology in mental health professions, and the ideology refers to the custodial philosophy versus the treatment philosophy. And clearly we do have an investment of ideology depending on where you work.

Q So you then, are not aware that the census in absolute numbers, has been reduced in the Georgia hospitals by five thousand five hundred since 1964?

A If that's the case, I'm very proud and very pleased to hear that.

Q And surprised?

A Not surprised. I've seen the decrease in the state hospital at Central State. I think I was very—when I went in 1964 it was tremendously crowded. But that doesn't mean that the State of Georgia can sleep on its laurals. There's no room for [41] us to be in any way complacent about what we're doing, not in the field of mental health.

Q You reviewed Daniel Offer's book, The Psychological World of the Teenager, is that correct?

A Correct.

Q Would you say that it's an accurate statement, that one of—let me ask you this way. Your review is basically complimentary to Doctor Offer's book?

A Yes.

Q What do you see as the major contribution which his study made in the field of adolescent psychology?

A Well, it's an emperical contribution in a field which

lacks in emperical contributions. If you look at my review you will see that in 1971 I reviewed the whole field of study of adolescent psychology so that—in 1971—so that from a viewpoint of reviewing the whole field that was a definite contribution. On the other hand, most of the study dealt with normal urban middle class adolescents, the ones who really have the least type of problem, or if they do, he didn't include it in his review. By his own admission twenty-three percent were excluded. If they showed any kind of psychiatric disturbance, he eliminated them completely from his study, which I think is unfortunate because then what we have, we have a discontinuous state of affair which he himself admitted. You have the mental health people working with upset adolescents say, well, adolescence is a time of . . . and extreme ups and downs, and his own data that indicates normal adolescence is not the case. I would suggest that that is, in terms of his data, a continuum of [42] adolescence disturbance. I agree with him that adolescence is no more of a crisis than any other crisis, so that if you take the analysis of when people most breakdown, you will see that people breakdown almost throughout their whole life cycle.

Q Well, I think you categorized a couple of concepts that have apparently been held prior to this work as myths. For example the myth of adolescence as a state of inner turmoil?

A Right.

Q You indicate to me in this review that you think Offer's work is substantial in disputing that myth, at least for the whole population. I mean that the myth . . .

A Yeah, you can generalize and say that adolescence is, you know, it's a time of turmoil for all adolescents. What

he found is a continuum. I mean he himself, with the three cases—three groups that he has, continuous growth, he calls it continuous growth, then he has the surgent group, and then he has the tumultuous adolescent, and by his own admission, very likely the fourth group, who represent the extremely disturbed group, so what he found, it was no different from the kind of thing that you find in any kind of population, which is a kind of a frequency distribution . . .

Q But isn't that somewhat different than the traditionally held view which was that this turmoil was a necessary part of adolescence? Isn't Freud's traditional theory that adolescence was necessarily a time of turbulence so that you could . . .

A By his own admission there are many mental health people, psychiatrists, psychoanalysts that still be believe that.

[43]

Q But in your own mind, and in this article, didn't you state that Offer made a substantial contribution to showing that this is not necessarily the truth?

A Yes. On the other hand, I do miss the connection between the relevance of this study and this work to the kind of issues that we've been dealing in.

Q Okay. Do you see any relevance, then, for the diagnosis of psychopathology in adolescents?

A I don't see that his contribution, if it's used—I hope that many psychiatrists or many psychologists will use his contribution to better diagnose adolescents. Unfortunately, again, if you take a family orientation, in some cases the adolescent's problems are strictly related to the problems of adolescence. So I would really feel that the

most relevant references you want for this particular time would be the work of Hans Stierlin. He published a book last year on separating adolescents from their parents and in this particular contribution, his method of treatment and what he talks about, he dealt with wayward, schizoid and drug addicts adolescents. And his contribution, to me, is much more relevant than Doctor Offer's contribution. And his major point is, that in dealing with adolescents, the major question he poses to the parents who use the adolescents as their scapegoat, is the fact that they are facing middle age, and he forces them to deal with their own facing death and middle age, and coming away from dealing with the adolescent. As soon as he does this, he's able to take the child—or the adolescent away from being scapegoated.

[44]

Q From Doctor Offer's book, The Psychological World of the Teenager, the study you just mentioned, and other research you might draw on, would you agree or disagree with the statement that it's almost impossible to identify the normal adolescent from an adolescent with psychopathology?

A Is it almost impossible?

Q Almost impossible to identify a normal adolescent from an adolescent with psychopathology?

A No, I think it's possible, yes.

Q You believe it's possible?

A Oh, yes. I think it's possible. If you have a whole continuum, you will have some extremely well adjusted adolescents, you're going to have some upset adolescents, which is most of us, and then you're going to have extremely sick adolescents. Naturally, what you're going to

have is the extremely upset adolescents you don't even have to examine. Their history, their whole behavior speaks for itself. They either are in jail or Juvenile Court, or in a variety of institutions. The group that you're talking about, the ones in the middle, or the ones toward the right side of the distribution, would be the only ones that there's going to be some difficulty in diagnosis. They're going to be borderline adolescents, and those are difficult. That is the borderline between health and non-health. And as in any kind of diagnostic decision, whether you have an adolescent, whether you have an adult, or whether you have an old person, the borderline between normal and abnormal, those are the difficult ones. So those are going to be the kind of adolescents that it's going to be very difficult to put into one side of the label or not.

[45]

Q But that would be true, I think you said, of any of the crisis periods of life?

A That's right.

Q And so there would not be any distinction between adolescence and crisis periods in adult life . . .

A Or children too, in some cases you have—and the crisis in some cases that you see in children may be in many cases, really the crisis that parents are having. Again, that's why we need to consider the whole system.

* * * * *

[1]

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

APPENDIX B

To Defendants' Supplemental Brief

AFFIDAVIT

Personally appeared before me, the undersigned officer, duly authorized to administer oaths, Sally Barr, who states upon oath as follows:

1.

I am Sally Barr, Statistician, for the Division of Mental Health and Mental Retardation, Department of Human Resources.

2.

I make this affidavit on personal knowledge and for use by the Defendants in the above-styled civil action.

3.

I personally prepared the exhibits attached hereto showing the distribution of the length of stay by number of children for each regional hospital and for the State from 1969 through 1975.

[2]

4.

The attached exhibits were prepared from the informations upplied by the hospital superintendents at depositions taken on December 4 and 5, 1975.

/s/SALLY BARR
Sally Barr
Statistician
Division of Mental Health and
Mental Retardation

Sworn to and subscribed
before me this 19th day
of December, 1975.

/s/Carolyn F. Peeples
Notary Public

Notary Public, Georgia State at Large
My Commission Expires April 23, 1979

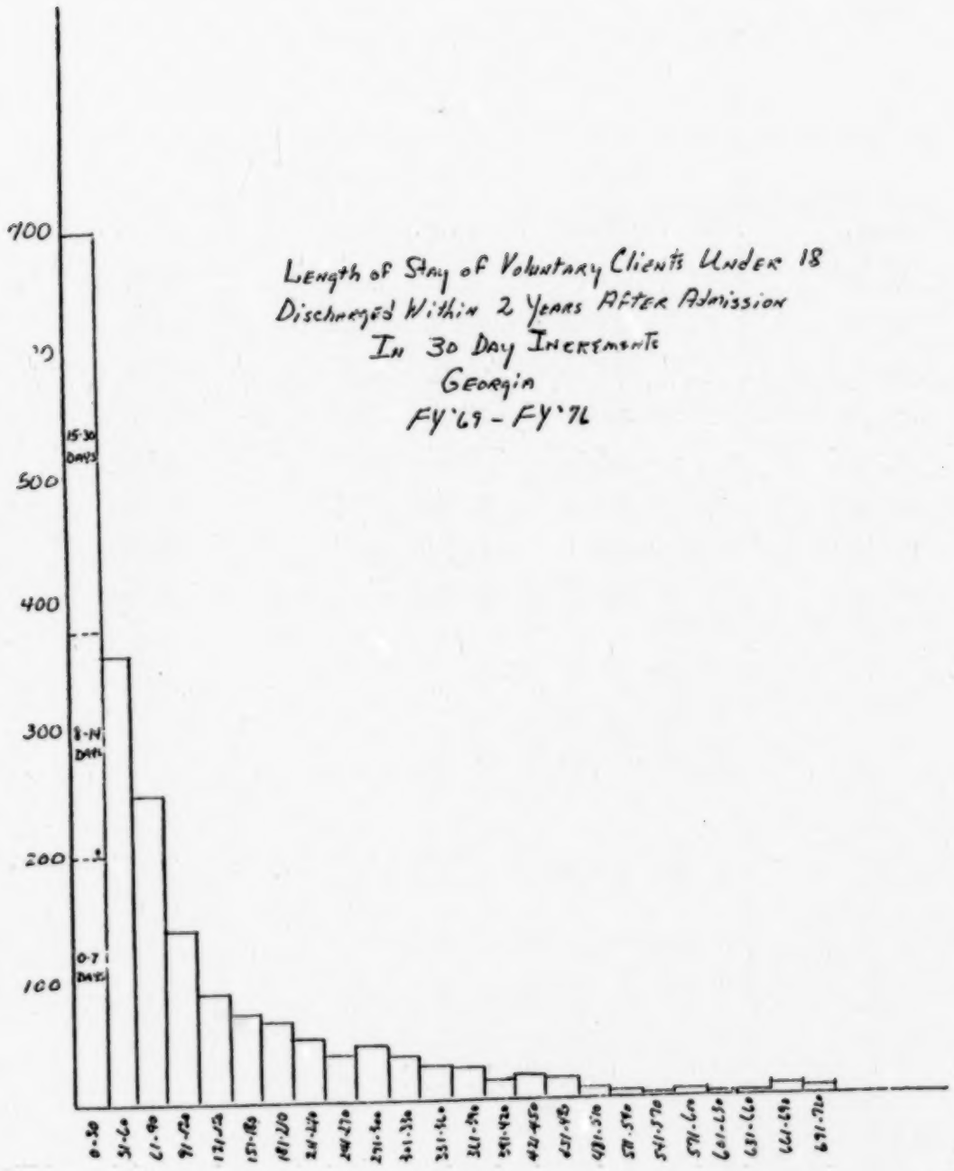
Length of Stay by Voluntarily Admitted Clients Under 18 Receiving Mental Health Services by Fiscal Year of Discharge
Georgia

	Days					Months *								Over 2 Yr
	0-7	8-14	15-30	31-60	61-90	0-3	4-6	7-9	10-12	13-15	16-18	20-21	22-24	
Total	197	178	317	365	245	1302	293	148	101	56	27	13	16	47
FY 69	1			2	5	8	4	3	3		2	2	1	1
FY 70	2	2	2	12	12	30	7	5	5	2	2	1		1
FY 71	4	3	12	11	14	44	27	12	6	4	1		1	2
FY 72	7	12	22	35	35	111	53	26	9	9	2	2	3	9
FY 73	26	34	63	64	39	226	72	46	32	14	4	1	3	5
FY 74	77	54	97	108	73	409	58	24	22	15	12	3	2	17
FY 75	65	57	92	103	56	313	54	30	17	8	4	2	5	12
FY 76	15	16	29	30	11	101	18	2	7	4		2	1	

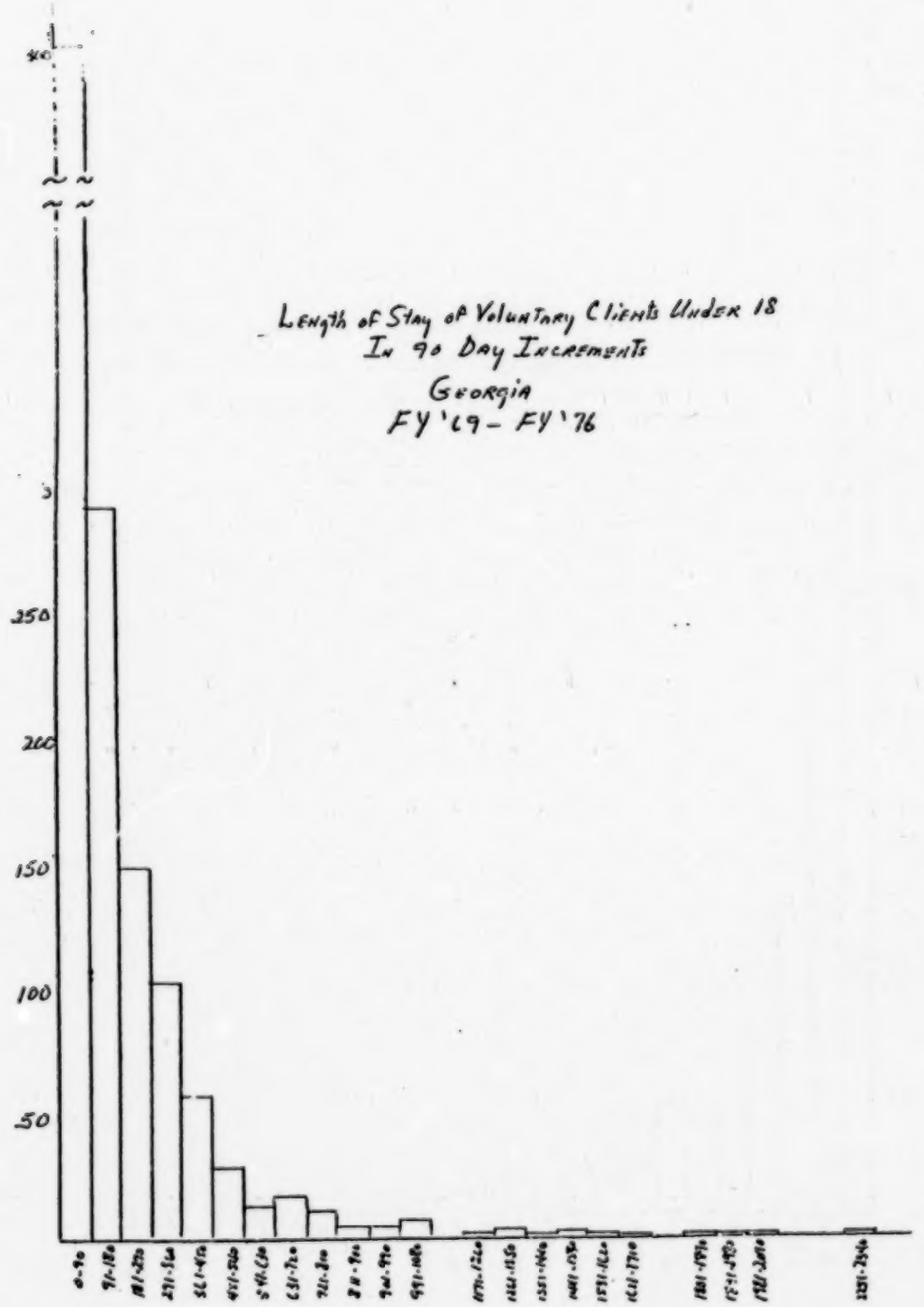
* Months are computed on basis of 30 days per month.

Number and Percent of Voluntary and Involuntary Admissions Of Clients Under 18 to Mental Health Services by Fiscal Year of Admission
Georgia

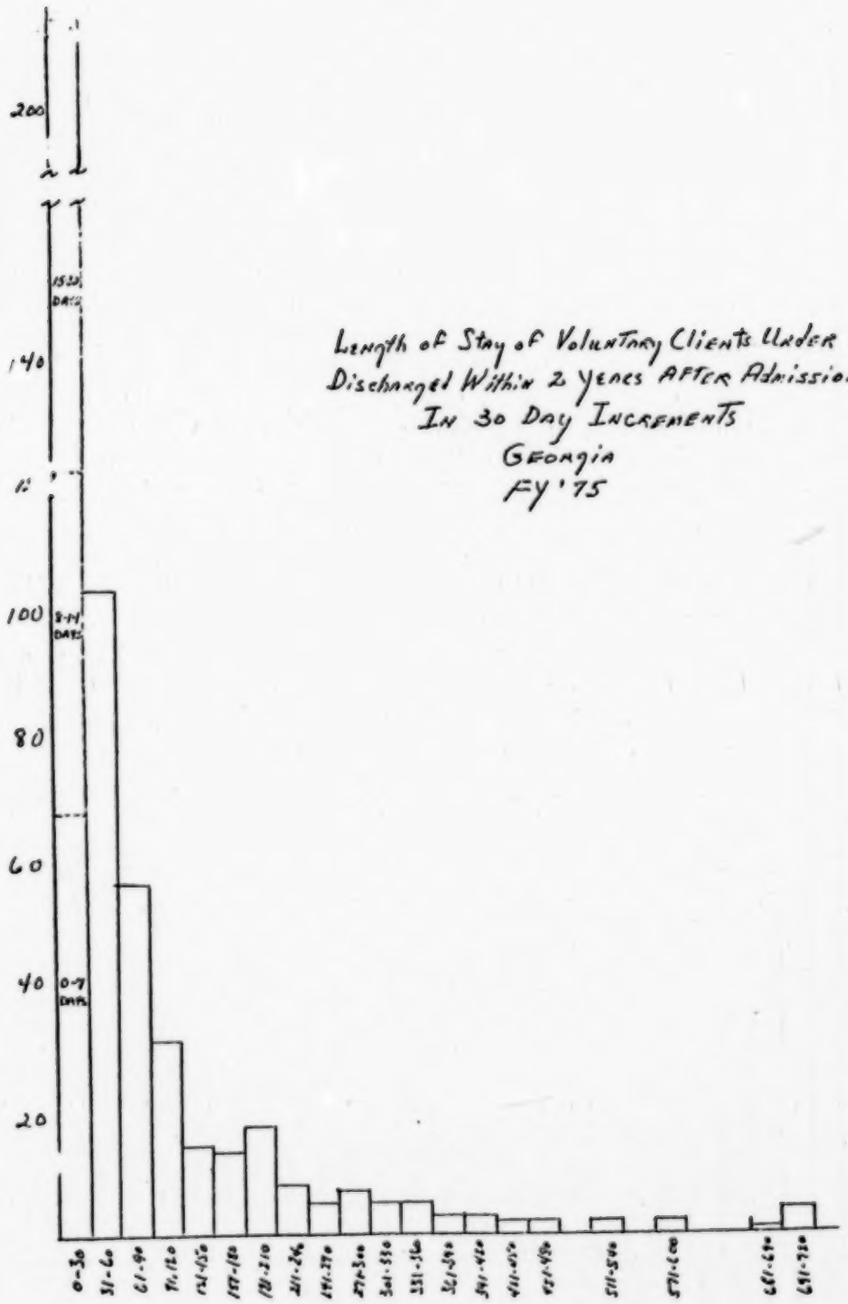
	Voluntary		Involuntary	
	Number	%	Number	%
Total	2039	65%	1111	35%
FY 69	50	35%	94	65%
FY 70	84	65%	46	35%
FY 71	131	82%	28	18%
FY 72	246	74%	88	26%
FY 73	458	72%	181	28%
FY 74	515	63%	297	37%
FY 75	445	58%	317	42%
FY 76	110	65%	60	35%



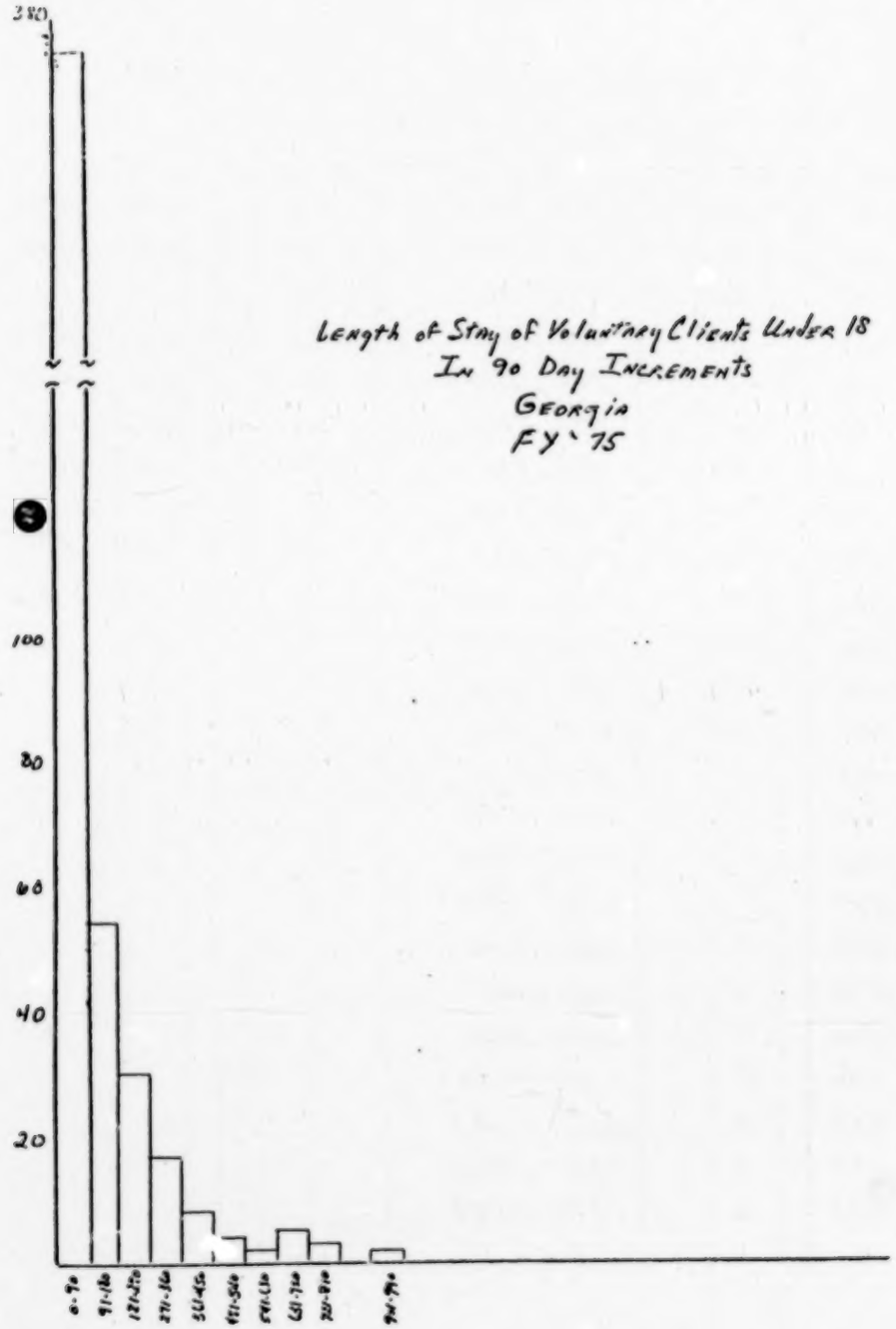
Length of Stay of Voluntary Clients Under 18
Discharged Within 2 Years After Admission
In 30 Day Increments
Georgia
FY '69 - FY '76



Length of Stay of Voluntary Clients Under 18
In 90 Day Increments
Georgia
FY '69 - FY '76



Length of Stay of Voluntary Clients Under 18
Discharged Within 2 Years AFTER Admission
IN 30 DAY INCREMENTS
GEORGIA
FY '75



Length of Stay of Voluntary Clients Under 18
IN 90 DAY INCREMENTS
GEORGIA
FY '75

Length of Stay by Voluntarily Admitted Clients Under 18 Receiving Mental Health Services by Fiscal Year of Discharge

Central State Hospital

	Days					Months*								Over 2 Y.
	0-7	8-14	15-30	31-60	61-90	0-3	4-6	7-9	10-12	13-15	16-18	20-21	22-24	
Total	15	16	22	50	54	157	70	41	36	25	13	8	11	29
FY 69	1			2	5	8	4	3	3		2	2	1	1
FY 70	2	1	2	7	10	22	3	4	5	2	2	1		1
FY 71	1	2	3	2	6	14	13	7	5	3	1		1	1
FY 72	1			2	3	6	10	5	2	4	1		2	4
FY 73	3	1	3	6	2	15	9	10	6	3	1		2	3
FY 74	1	3	4	10	13	31	11	7	6	8	3	2	1	12
FY 75	4	8	8	19	13	52	15	5	7	2	3	2	3	7
FY 76	2	1	2	2	2	9	5		2	3		1	1	

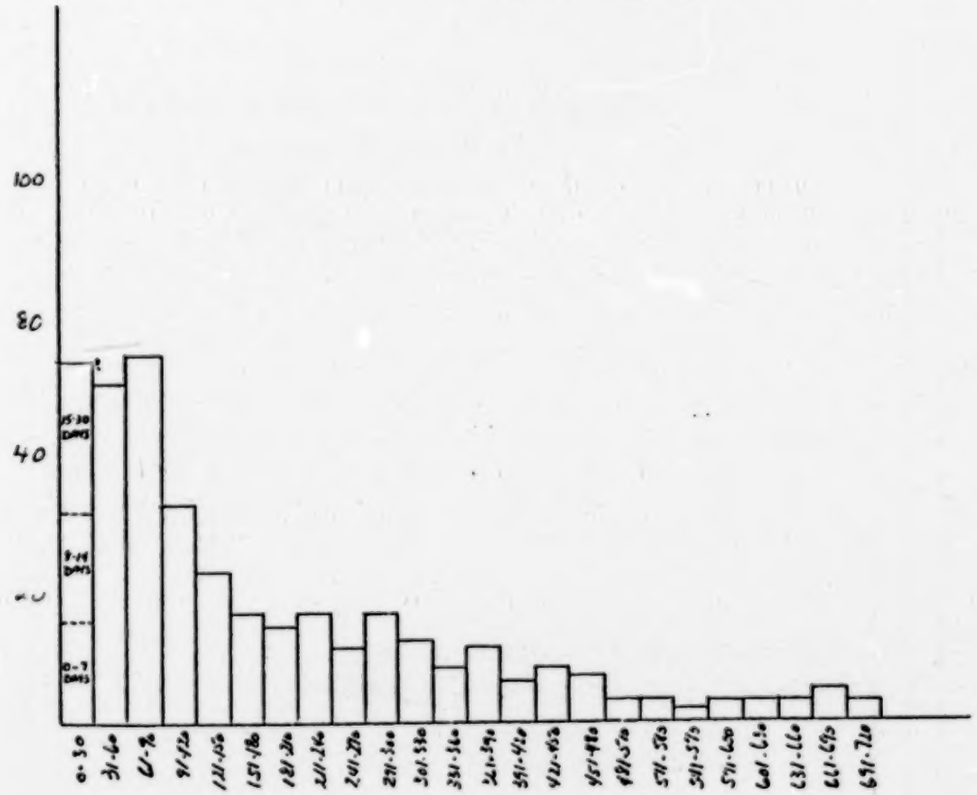
*Months are computed on basis of 30 days per month

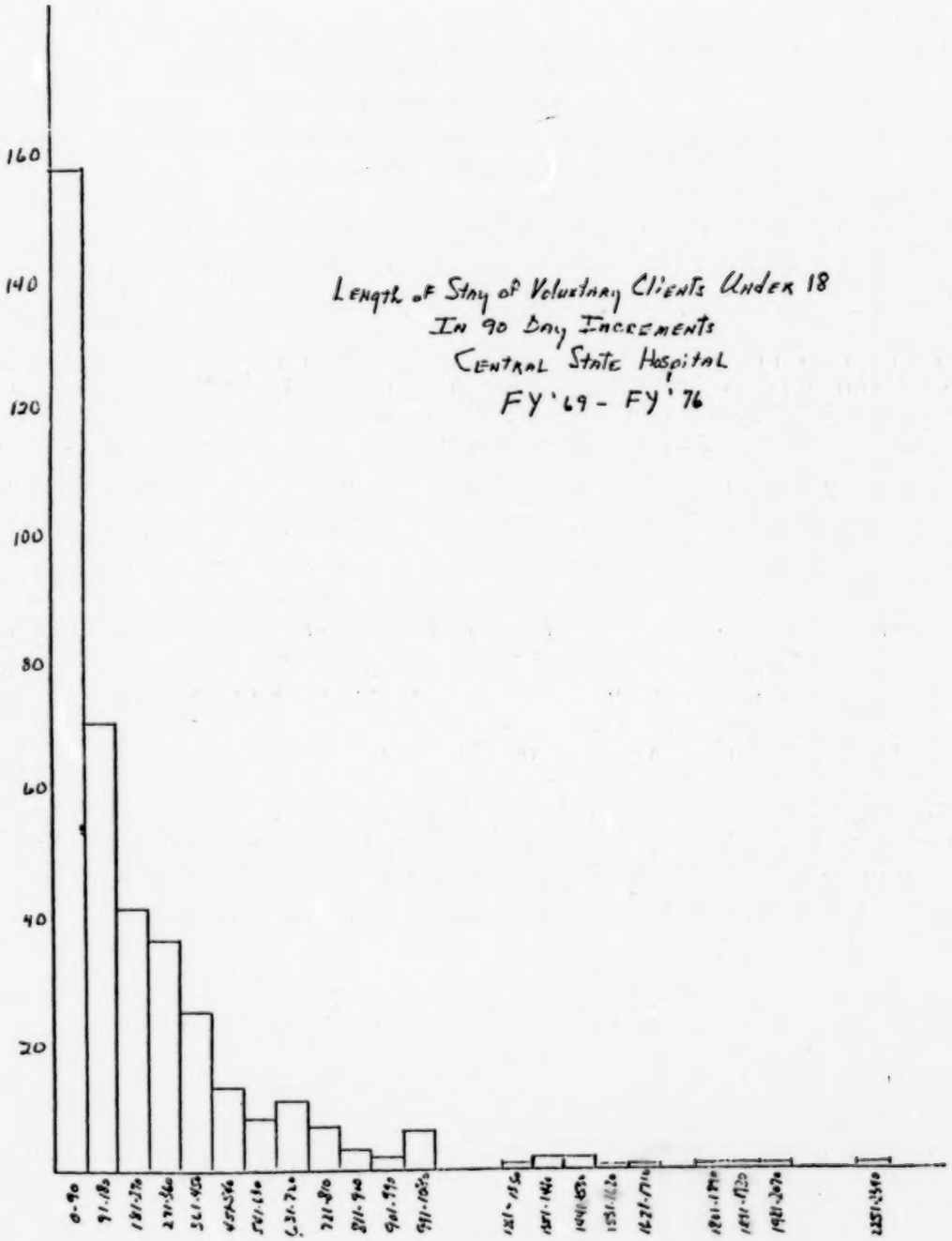
Number and Percent of Voluntary and Involuntary Admissions
Of Clients Under 18 to Mental Health Services
by Fiscal Year of Admission

Central State Hospital

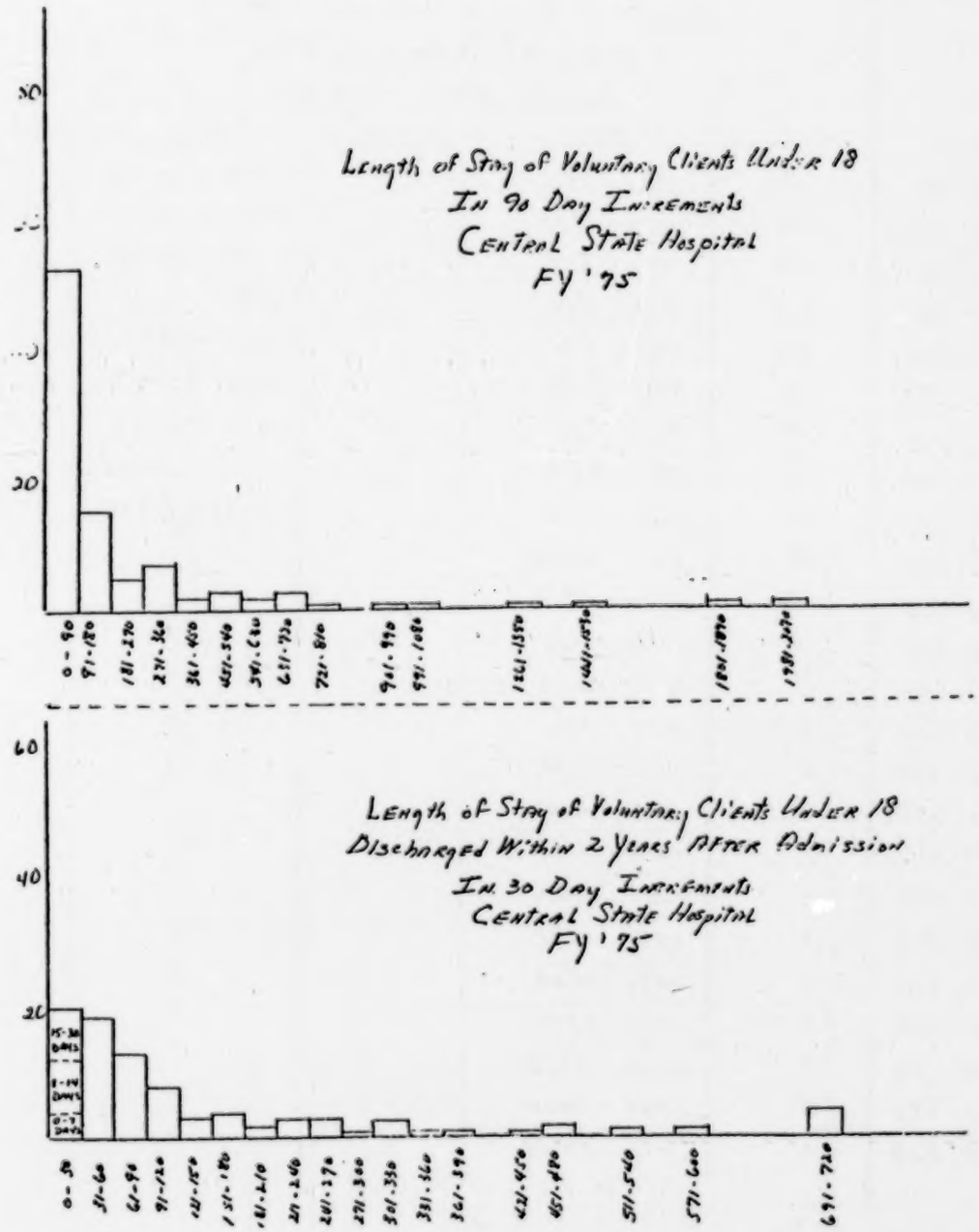
	Voluntary		Involuntary	
	Number	%	Number	%
Total	390	50%	386	50%
FY 69	47	34%	93	66%
FY 70	50	53%	44	47%
FY 71	50	69%	22	31%
FY 72	46	55%	37	45%
FY 73	54	67%	27	33%
FY 74	66	49%	70	51%
FY 75	68	44%	86	56%
FY 76	9	56%	7	44%

Length of Stay of Voluntary Clients Under 18
Discharged Within 2 Years After Admission
In 30 Day Increments
Central State Hospital
FY '69 - FY '76





Length of Stay of Voluntary Clients Under 18
In 90 Day Increments
Central State Hospital
FY '69 - FY '76



Length of Stay of Voluntary Clients Under 18
In 90 Day Increments
Central State Hospital
FY '75

Length of Stay of Voluntary Clients Under 18
Discharged Within 2 Years After Admission
In 30 Day Increments
Central State Hospital
FY '75

Length of Stay by Voluntarily Admitted Clients Under 18 Receiving Mental Health Services by Fiscal Year of Discharge
Central State Hospital

Days	# of Clients	Days	# of Clients	Days	# of Clients
0 - 30	53	721 - 750	4	1441 - 1470	1
31 - 60	50	751 - 780	2	1471 - 1500	2
61 - 90	54	781 - 810	1	1501 - 1530	1
91 - 120	32	811 - 840	2	1591 - 1620	1
121 - 150	22	841 - 870	1	1651 - 1680	1
151 - 180	16	871 - 900	1	1861 - 1890	1
181 - 210	14	901 - 930	1	1921 - 1950	1
211 - 240	16	931 - 960	1	2011 - 2040	1
241 - 270	11	961 - 990		2281 - 2310	1
271 - 300	16	991 - 1020	3		
301 - 330	12	1021 - 1050	1		
331 - 360	8	1051 - 1080	2		
361 - 390	11	1081 - 1110			
391 - 420	6	1111 - 1140			
421 - 450	8	1141 - 1170			
451 - 480	7	1171 - 1200			
481 - 510	3	1201 - 1230			
511 - 540	3	1231 - 1260			
541 - 570	2	1261 - 1290			
571 - 600	3	1291 - 1320	3		
601 - 630	3	1321 - 1350			
631 - 660	3	1351 - 1380			
661 - 690	5	1381 - 1410	1		
691 - 720	3	1411 - 1440	1		

Length of Stay by Voluntarily Admitted Clients Under 18 Receiving
Mental Health Services by Fiscal Year of Discharge
Southwestern State Hospital

	Days					Months*								
	0-7	8-14	15-30	31-60	61-90	0-3	4-6	7-9	10-12	13-15	16-18	20-21	22-24	Over 2 Yrs
Total	10	20	14	10	3	57	6	2	2	2	1		1	1
FY 69														
FY 70														
FY 71														
FY 72			1	4		5	1							
FY 73	6	5	2		2	15	1		1	1	1			
FY 74	1	8	2	1		12	2			1				
FY 75	3	4	5	3		15		2					1	1
FY 76		3	4	2	1	10	2		1					

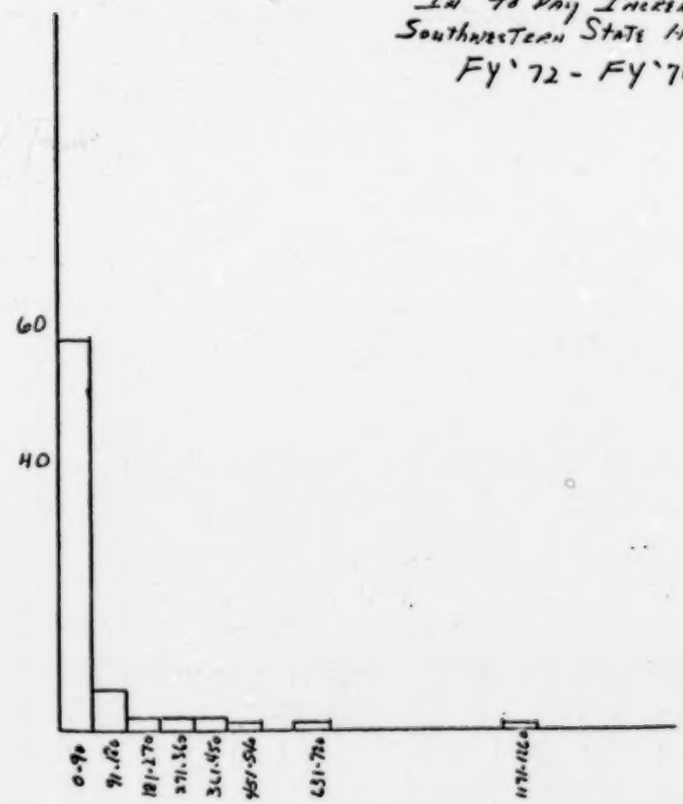
*Months are computed on basis of 30 days per month.

Number and Percent of Voluntary and Involuntary Admissions
Of Clients Under 18 to Mental Health Services
by Fiscal Year of Admission

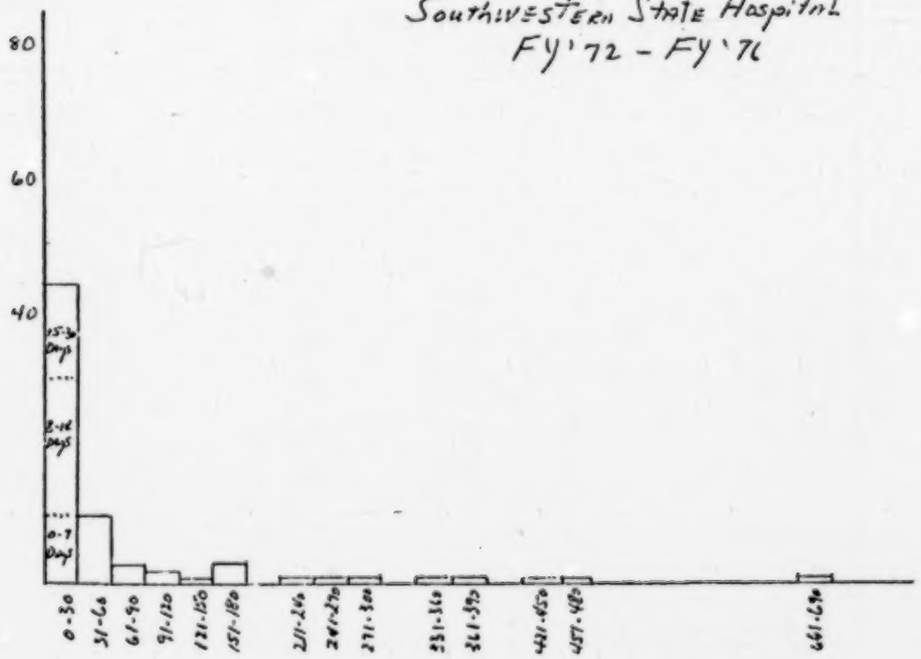
Southwestern State Hospital

	Voluntary		Involuntary	
	Number	%	Number	%
Total	79	65%	43	35%
FY 69				
FY 70				
FY 71				
FY 72	10	42%	14	58%
FY 73	24	80%	6	20%
FY 74	12	57%	9	43%
FY 75	13	68%	6	32%
FY 76	20	71%	8	29%

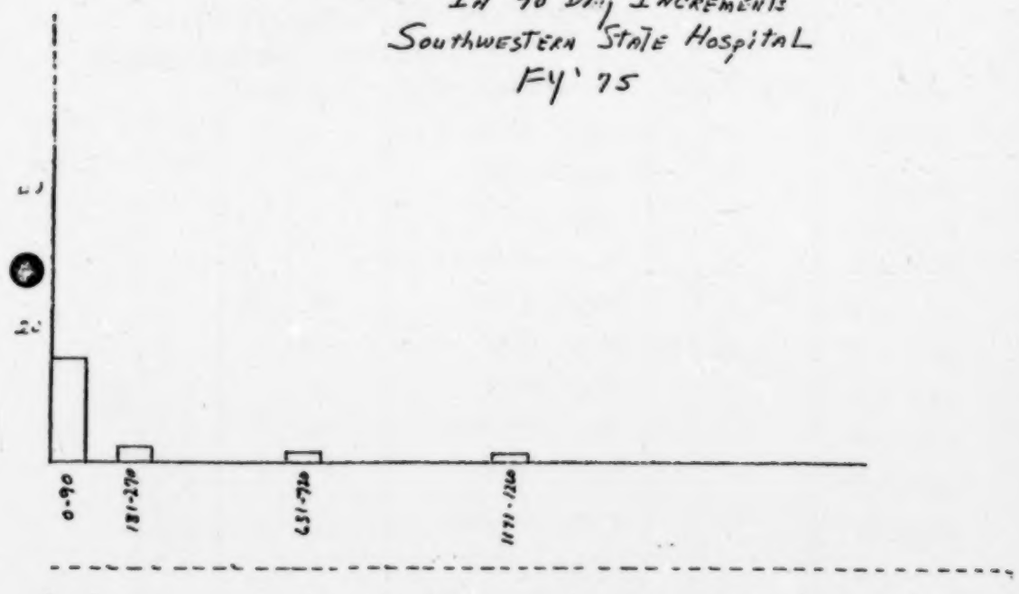
Length of Stay of Voluntary Clients Under 18
In 90 Day Increments
Southwestern State Hospital
FY '72 - FY '76



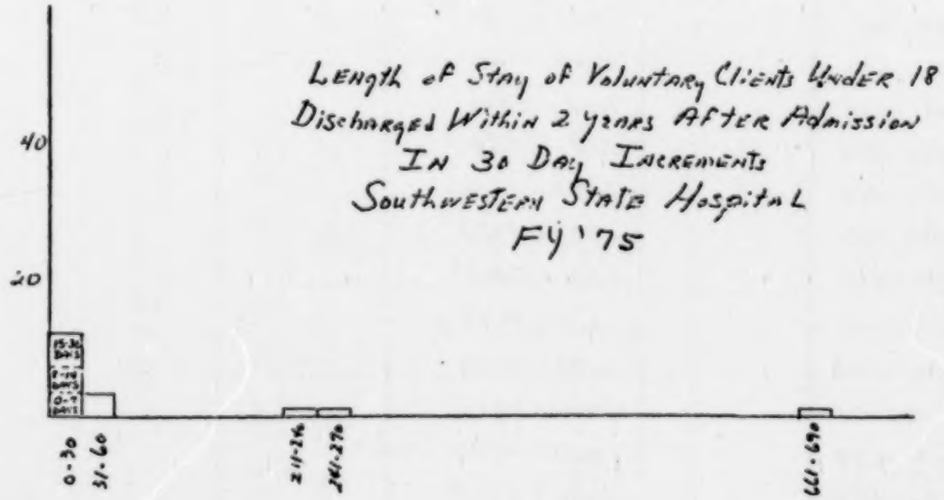
Length of Stay of Voluntary Clients Under 18
Discharged Within 2 Years After Admission
In 30 Day Increments
Southwestern State Hospital
FY '72 - FY '76



Length of Stay of Voluntary Clients Under 18
In 90 Day Increments
Southwestern State Hospital
FY '75



Length of Stay of Voluntary Clients Under 18
Discharged Within 2 years After Admission
In 30 Day Increments
Southwestern State Hospital
FY '75



Length of Stay by Voluntarily Admitted Clients Under 18 - 30 Day Interval
Georgia Mental Health Institute

Days	# of Clients	Days	# of Clients	Days	# of Clients
0 - 30	44	721 - 750		1441 - 1470	
31 - 60	10	751 - 780		1471 - 1500	
61 - 90	3	781 - 810			
91 - 120	2	811 - 840			
121 - 150	1	841 - 870			
151 - 0	3	871 - 900			
181 - 210		901 - 930			
211 - 240	1	931 - 960			
241 - 270	1	961 - 990			
271 - 300	1	991 - 1020			
301 - 330		1021 - 1050			
331 - 360	1	1051 - 1080			
361 - 390	1	1081 - 1110			
391 - 420		1111 - 1140			
421 - 450	1	1141 - 1170			
451 - 480	1	1171 - 1200	1		
481 - 510		1201 - 1230			
511 - 540		1231 - 1260			
541 - 570		1261 - 1290			
571 - 600		1291 - 1320			
31 - 630		1321 - 1350			
631 - 660		1351 - 1380			
661 - 690	1	1381 - 1410			
691 - 720		1411 - 1440			

Length of Stay by Voluntarily Admitted Clients Under 18 Receiving
Mental Health Services by Fiscal Year of Discharge
Ga. Mental Health Institute

	Days					Months*								
	0-7	8-14	15-30	31-60	61-90	0-3	4-6	7-9	10-12	13-15	16-18	20-21	22-24	Over 2 Yrs
Total	29	18	38	39	41	165	83	39	14	14	7	1		3
FY 69														
FY 70														
FY 71	1	1	4	1	5	12	7	3						
FY 72		2	4	10	8	24	25	11	3	2				1
FY 73	4	1	2	10	8	25	24	8	4	5	1			1
FY 74	14	7	7	8	12	48	19	6	4	4	6	1		
FY 75	10	7	21	10	8	56	8	11	3	3				1
FY 76														

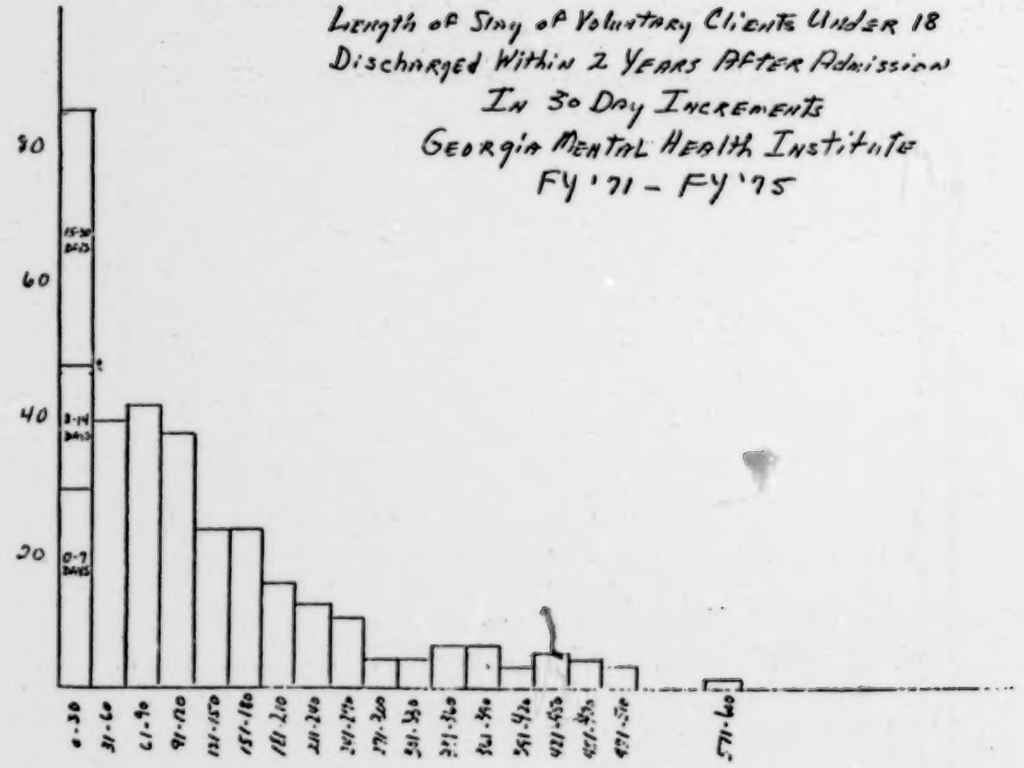
*Months are computed on basis of 30 days per month.

Number and Percent of Voluntary and Involuntary Admissions
Of Clients Under 18 to Mental Health Services
by Fiscal Year of Admission

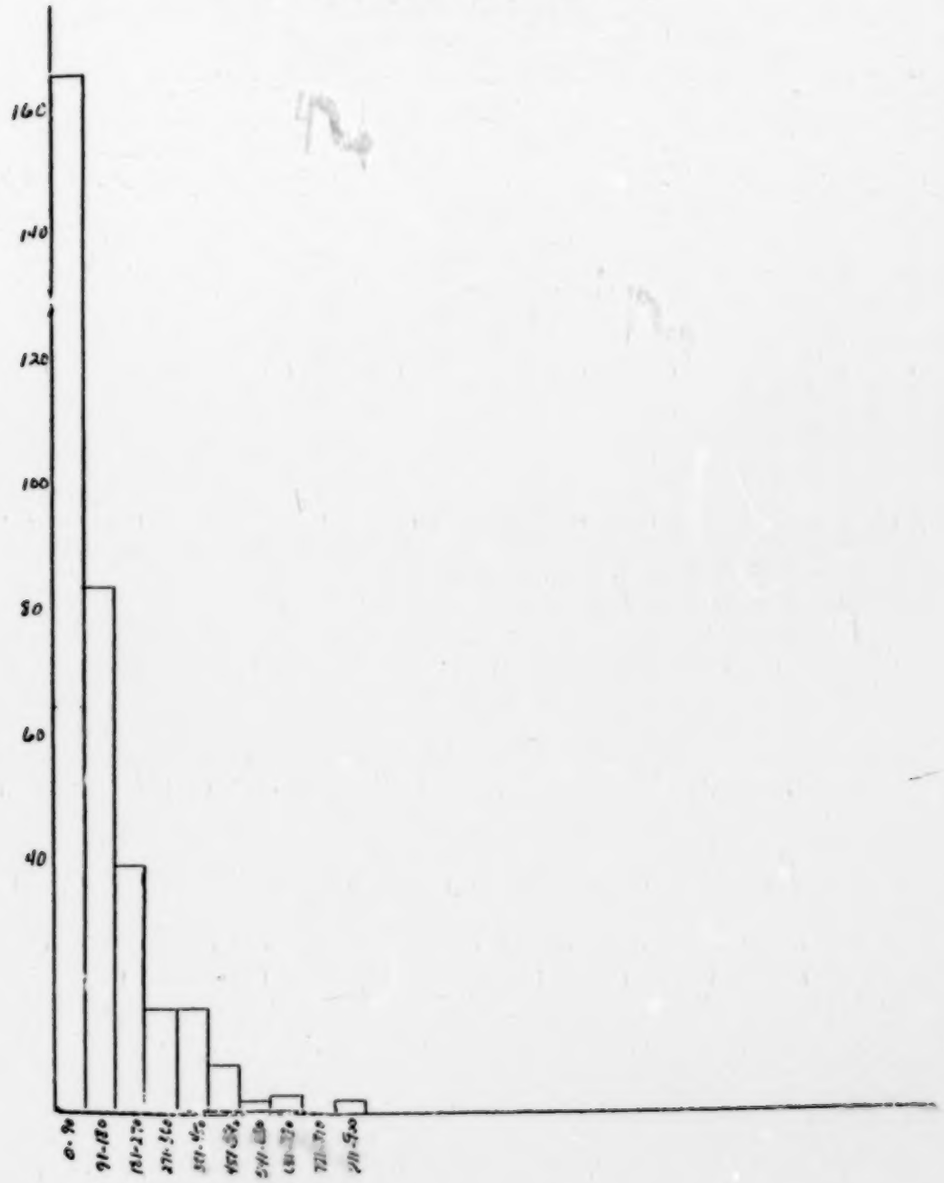
Ga. Mental Health Institute

	Voluntary		Involuntary	
	Number	%	Number	%
Total	326	96%	15	4%
FY 69				
FY 70	1	100%		
FY 71	40	100%		
FY 72	70	100%		
FY 73	72	100%		
FY 74	81	94%	5	6%
FY 75	62	86%	10	14%
FY 76				

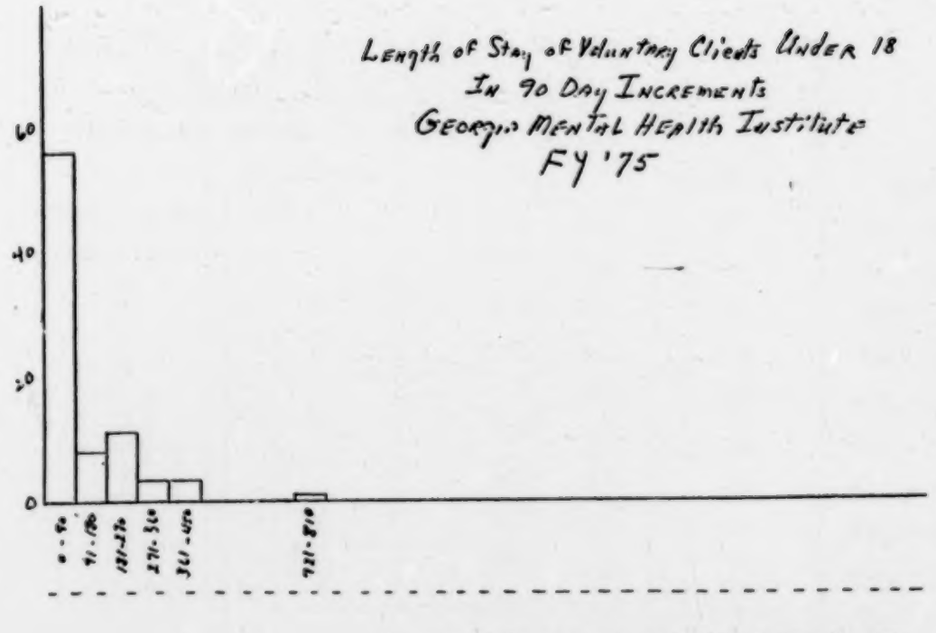
Length of Stay of Voluntary Clients Under 18
Discharged Within 2 Years After Admission
In 30 Day Increments
Georgia Mental Health Institute
FY '71 - FY '75



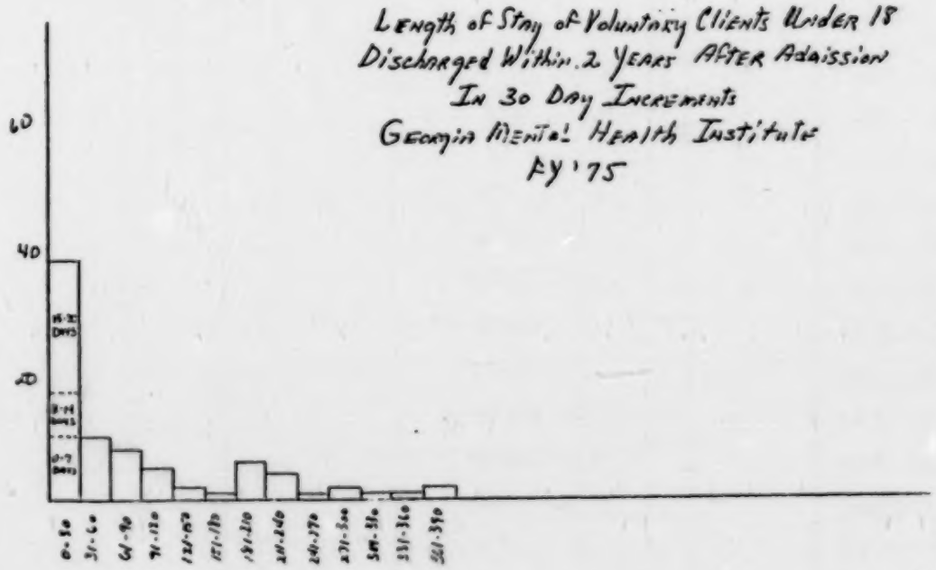
Length of Stay of Voluntary Clients Under 18
In 90 Day Increments
Georgia Mental Health Institute
FY '71 – FY '75



Length of Stay of Voluntary Clients Under 18
In 90 Day Increments
Georgia Mental Health Institute
FY '75



Length of Stay of Voluntary Clients Under 18
Discharged Within 2 Years After Admission
In 30 Day Increments
Georgia Mental Health Institute
FY '75



Length of Stay of Voluntary Clients
Under 18 - 30 Day Interval
Georgia Mental Health Institute

Days	# of Clients	Days	# of Clients	
0 - 30	85	721 - 750		1441 - 1470
31 - 60	39	751 - 780		1471 - 1500
61 - 90	41	781 - 810	1	
91 - 120	37	811 - 840		
121 - 150	23	841 - 870		
1 - 180	23	871 - 900		
181 - 210	15	901 - 930		
211 - 240	12	931 - 960	1	
241 - 270	10	961 - 990		
271 - 300	4	991 - 1020		
301 - 330	4	1021 - 1050		
331 - 360	6	1051 - 1080		
361 - 390	6	1081 - 1110		
391 - 420	3	1111 - 1140		
421 - 450	5	1141 - 1170		
451 - 480	4	1171 - 1200		
481 - 510	3	1201 - 1230		
511 - 540		1231 - 1260		
541 - 570		1261 - 1290		
571 - 600	1	1291 - 1320		
601 - 630		1321 - 1350		
631 - 660		1351 - 1380		
661 - 690		1381 - 1410		
691 - 720		1411 - 1440		

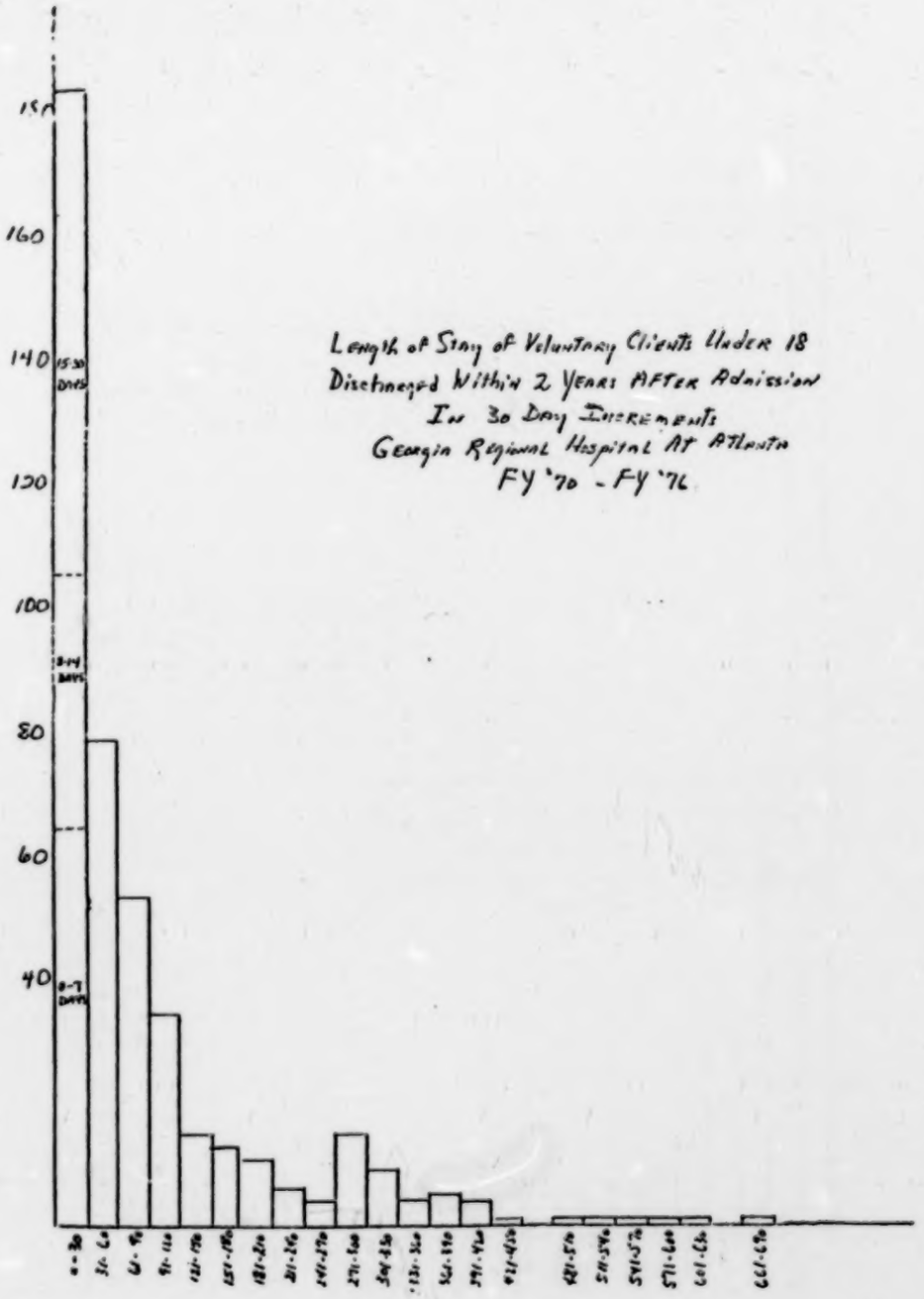
Length of Stay by Voluntarily Admitted Clients Under 18 Receiving
Mental Health Services by Fiscal Year of Discharge
Ga. Regional Hospital at Atlanta

	Days				Months*						
	0-7	8-14	15-30	31-60	61-90	0-3	4-6	7-9	10-12	13-15	16-18	20-21	22-24	Over 2 Yrs.
Total	64	41	78	78	58	314	62	21	28	10	5	3	4	14
FY 69							4	1						1
FY 70		1		5	2	8	7	2	1	1				4
FY 71	2		5	8	3	18	5	5	4	3	1	2	1	1
FY 72	4	2	3	4	10	23	12	1	9	2	1		1	5
FY 73	4	7	14	9	7	41	12	1	5	1	3		1	3
FY 74	25	13	28	22	16	104	16	9	6	2			1	
FY 75	25	14	22	22	14	97	6	2	3	1		1		
FY 76	4	4	6	8	1	23								

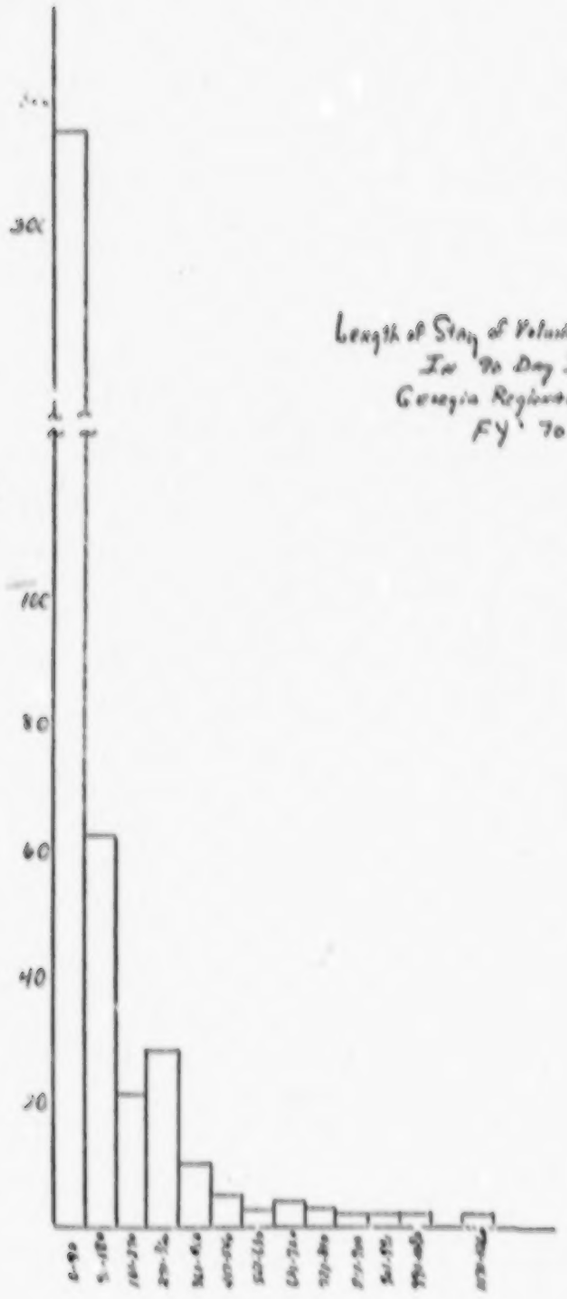
*Months are computed on basis of 30 days per month.

Number and Percent of Voluntary and Involuntary Admissions
Of Clients Under 18 to Mental Health Services
by Fiscal Year of Admission
GEORGIA REGIONAL HOSPITAL AT ATLANTA

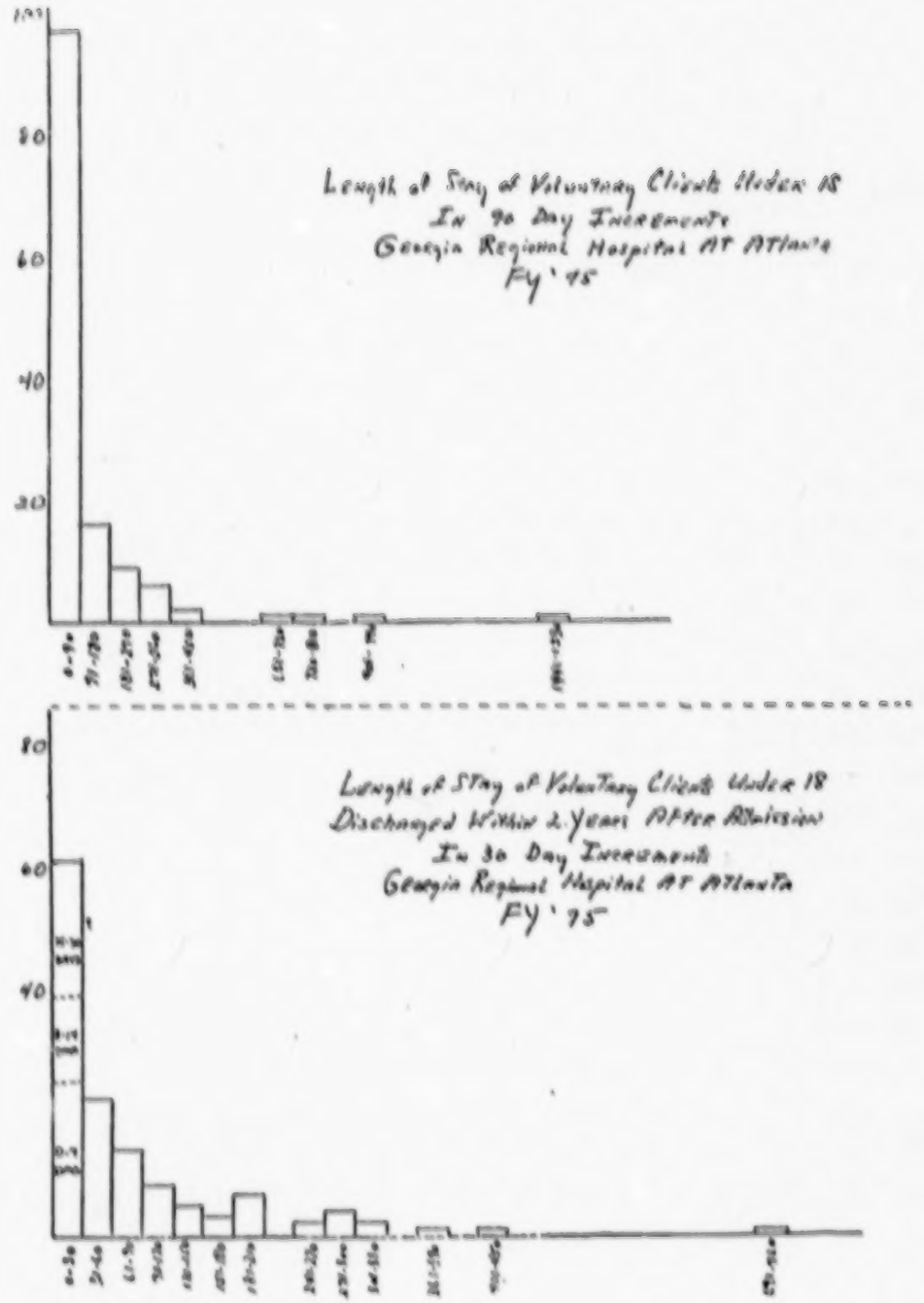
	Voluntary Number	%	Involuntary Number	%
Total	474	74%	168	26%
FY 69	3	75%	1	25%
FY 70	33	94%	2	6%
FY 71	41	87%	6	13%
FY 72	45	74%	16	26%
FY 73	76	74%	26	26%
FY 74	126	68%	60	32%
FY 75	134	75%	45	25%
FY 76	16	57%	12	43%



Length of Stay of Voluntary Clients Under 18
Discharged Within 2 Years After Admission
In 30 Day Increments
Georgia Regional Hospital At Atlanta
FY '70 - FY '76



Length of Stay of Voluntary Clients Under 18
In 30 Day Increments
Georgia Regional Hospital AT Atlanta
FY '70 - FY '76



Length of Stay of Voluntary Clients Under 18
In 30 Day Increments
Georgia Regional Hospital AT Atlanta
FY '75

Length of Stay of Voluntary Clients Under 18
Discharged Within 2 Years After Admission
In 30 Day Increments
Georgia Regional Hospital AT Atlanta
FY '75

Length of Stay of Voluntary Clients
Under 18 - 30 Day Intervals
Georgia Regional Hospital at Atlanta

Days	# of Clients	Days	# of Clients	Days	# of Clients
0 - 30	133	721 - 750		1441 - 1470	
31 - 60	78	751 - 780	2	1471 - 1500	1
61 - 90	53	781 - 810	1		
91 - 120	34	811 - 840	1	1561 - 1590	1
121 - 150	15	841 - 870			
151 - 180	13	871 - 900	1		
181 - 210	11	901 - 930	2		
211 - 240	6	931 - 960			
241 - 270	4	961 - 990			
271 - 300	15	991 - 1020	1		
301 - 330	9	1021 - 1050	1		
331 - 360	4	1051 - 1080			
361 - 390	5	1081 - 1110			
391 - 420	4	1111 - 1140			
421 - 450	1	1141 - 1170			
451 - 480	3	1171 - 1200			
481 - 510	1	1201 - 1230			
511 - 540	1	1231 - 1260			
541 - 570	1	1261 - 1290			
571 - 600	1	1291 - 1320	2		
601 - 630	1	1321 - 1350			
631 - 660		1351 - 1380			
661 - 690	1	1381 - 1410			
691 - 720	3	1411 - 1440			

Length of Stay by Voluntarily Admitted Clients Under 18 Receiving
Mental Health Services by Fiscal Year of Discharge
Ga. Regional Hospital at Augusta

	Days					Months					Over 2 Yrs
	0-7	8-14	15-30	31-60	61-90	0-3	4-6	7-9	10-12	13-15	16-18	20-21	22-24	
Total	51	46	77	72	48	294	22	13	5		1	1		
FY 69														
FY 70												1		
FY 71														
FY 72											1			
FY 73	5	8	10	11	10	44	7	5						
FY 74	20	11	28	24	20	103	7	5	5					
FY 75	18	20	25	25	15	116	7	3			1			
FY 76	8	7	11	12	3	41	1							

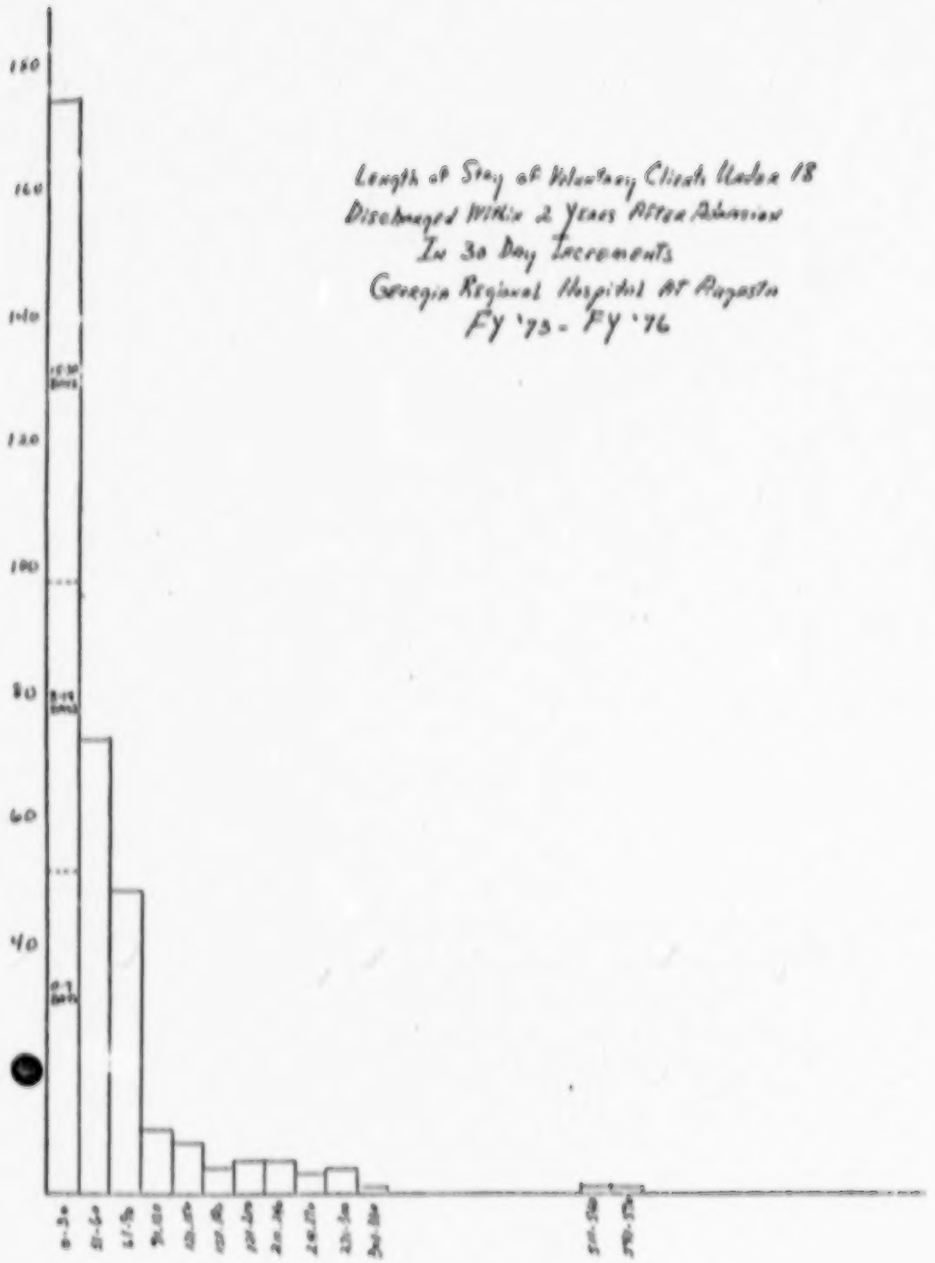
* Months are computed on basis of 30 days per month.

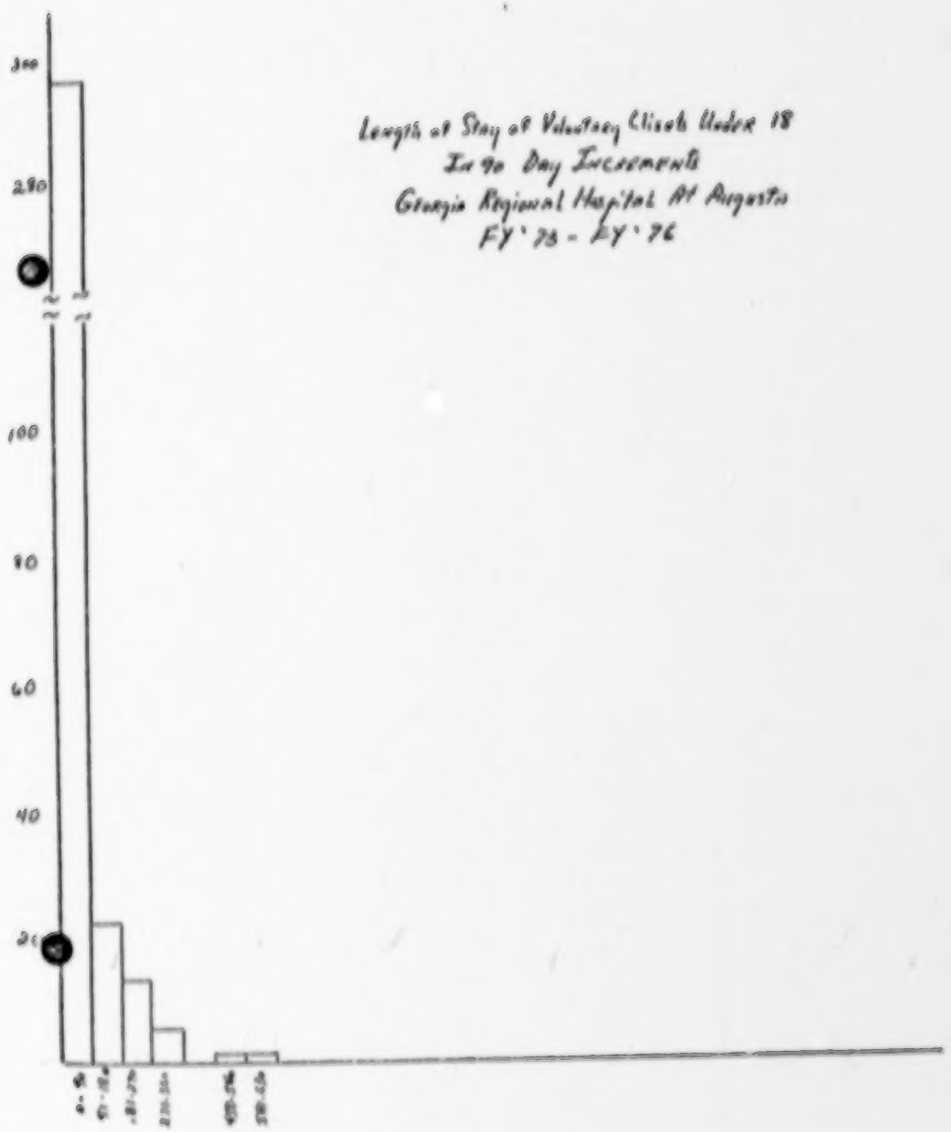
Number and Percent of Voluntary and Involuntary Admissions
Of Clients Under 18 to Mental Health Services
by Fiscal Year of Admission

Ga. Regional Hospital at Augusta

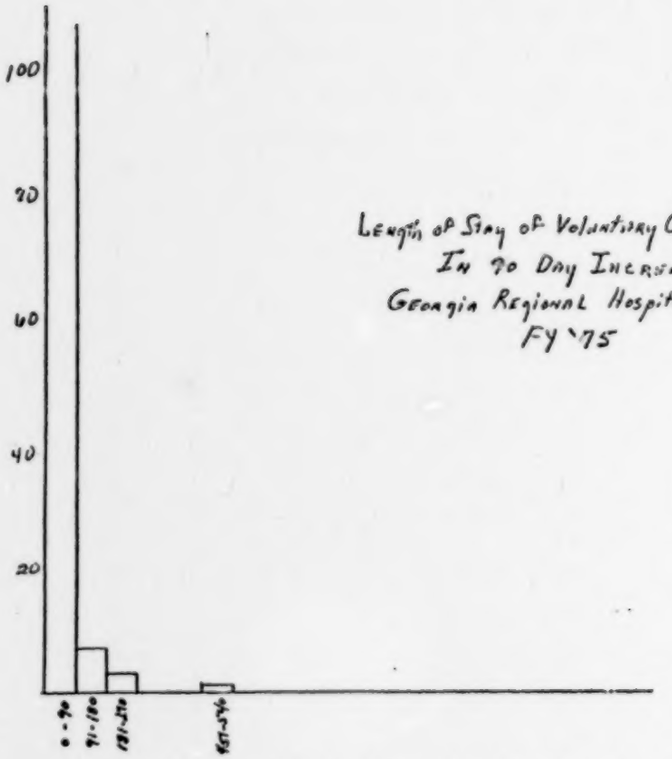
	Voluntary		Involuntary	
	Number	%	Number	%
Total	336	57%	252	43%
FY 69				
FY 70				
FY 71				
FY 72	5	83%	1	17%
FY 73	84	60%	56	40%
FY 74	108	55%	88	45%
FY 75	107	55%	88	45%
FY 76	32	63%	19	37%

Length of Stay of Voluntary Clients Under 18
Discharged Within 2 Years After Admission
In 30 Day Increments
Georgia Regional Hospital At Augusta
FY '73 - FY '76

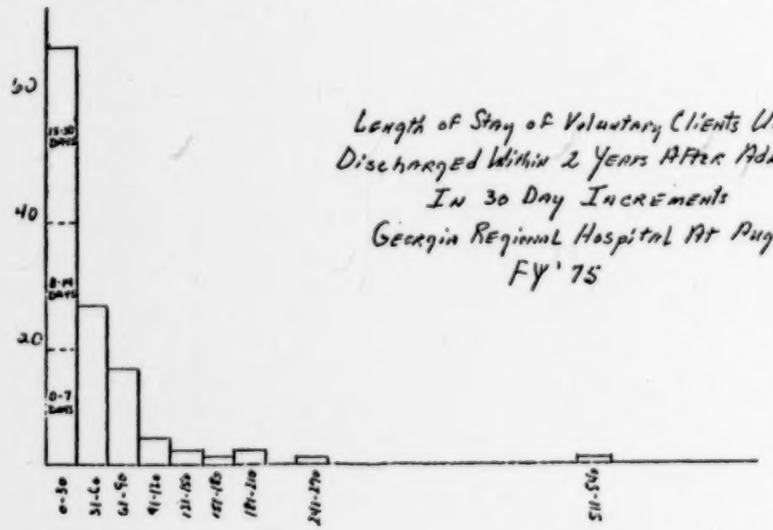




Length of Stay of Voluntary Clients Under 18
In 30 Day Increments
Georgia Regional Hospital At Augusta
FY '75 - FY '76



Length of Stay of Voluntary Clients Under 18
In 30 Day Increments
Georgia Regional Hospital At Augusta
FY '75



Length of Stay of Voluntary Clients Under 18
Discharged Within 2 Years After Admission
In 30 Day Increments
Georgia Regional Hospital At Augusta
FY '75

Length of Stay of Voluntary Clients
Under 18 - 30 Day Intervals
Georgia Regional Hospital at Augusta

Days	# of Clients	Days	# of Clients		
0 - 30	174	721 - 750		1441 - 1470	
31 - 60	72	751 - 780		1471 - 1500	
61 - 90	48	781 - 810			
91 - 120	10	811 - 840			
121 - 150	8	841 - 870			
151 - 180	4	871 - 900			
181 - 210	5	901 - 930			
211 - 240	5	931 - 960			
241 - 270	3	961 - 990			
271 - 300	4	991 - 1020			
301 - 330	1	1021 - 1050			
331 - 360		1051 - 1080			
361 - 390		1081 - 1110			
391 - 420		1111 - 1140			
421 - 450		1141 - 1170			
451 - 480		1171 - 1200			
481 - 510		1201 - 1230			
511 - 540	1	1231 - 1260			
541 - 570	1	1261 - 1290			
571 - 600		1291 - 1320			
601 - 630		1321 - 1350			
631 - 660		1351 - 1380			
661 - 690		1381 - 1410			
691 - 720		1411 - 1440			

Length of Stay by Voluntarily Admitted Clients Under 18 Receiving Mental Health Services by Fiscal Year of Discharge
GEORGIA REGIONAL AT SAVANNAH

	Days 0-7	8-14	15-30	31-60	61-90	Months* 0-3	4-6	7-9	10-12	13-15	16-18	20-21	22-24
Total	21	36	85	114	45	307	47	32	16	5			
FY 69							12	5					
FY 70							19	22	12	3			
FY 71							7	5	2	1			
FY 72	2	9	14	15	14	53	9		1	1			
FY 73	4	12	32	28	10	86	1		1				
FY 74	16	12	28	43	12	111							
FY 75	4	4	7	23	6	44							
FY 76	1		4	5	3	13							

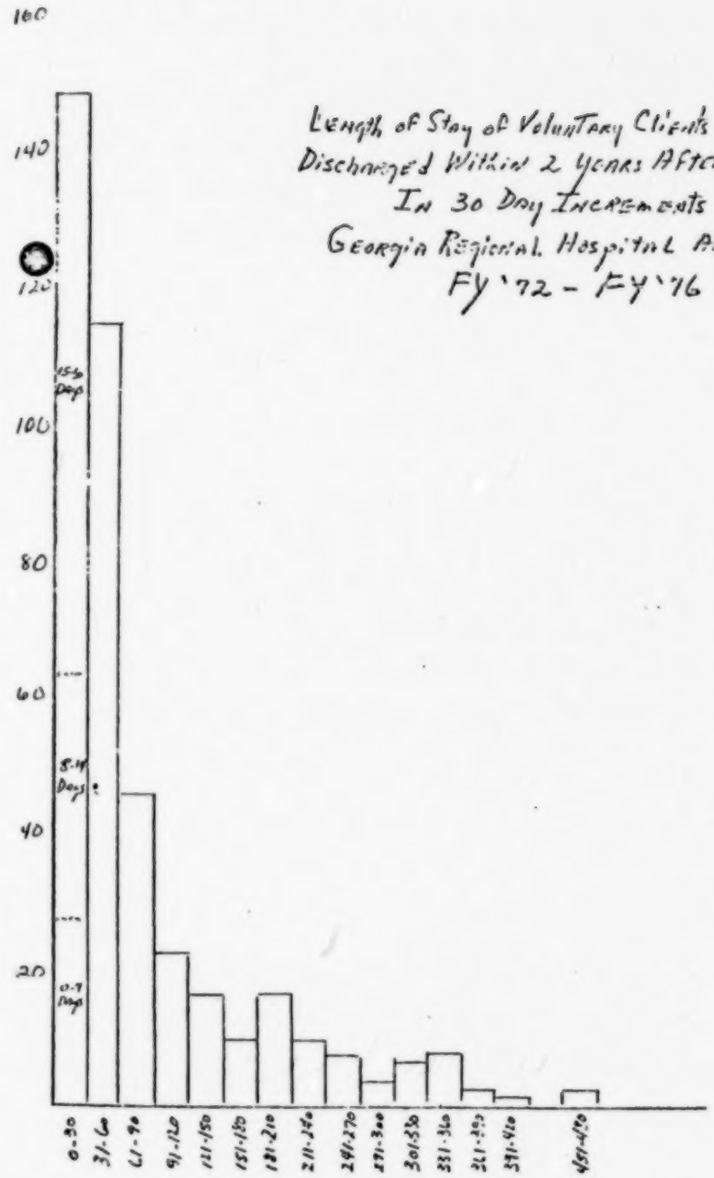
* Months are computed on basis of 30 days per month.

Number and Percent of Voluntary and Involuntary Admissions
Of Clients Under 18 to Mental Health Services
by Fiscal Year of Admission

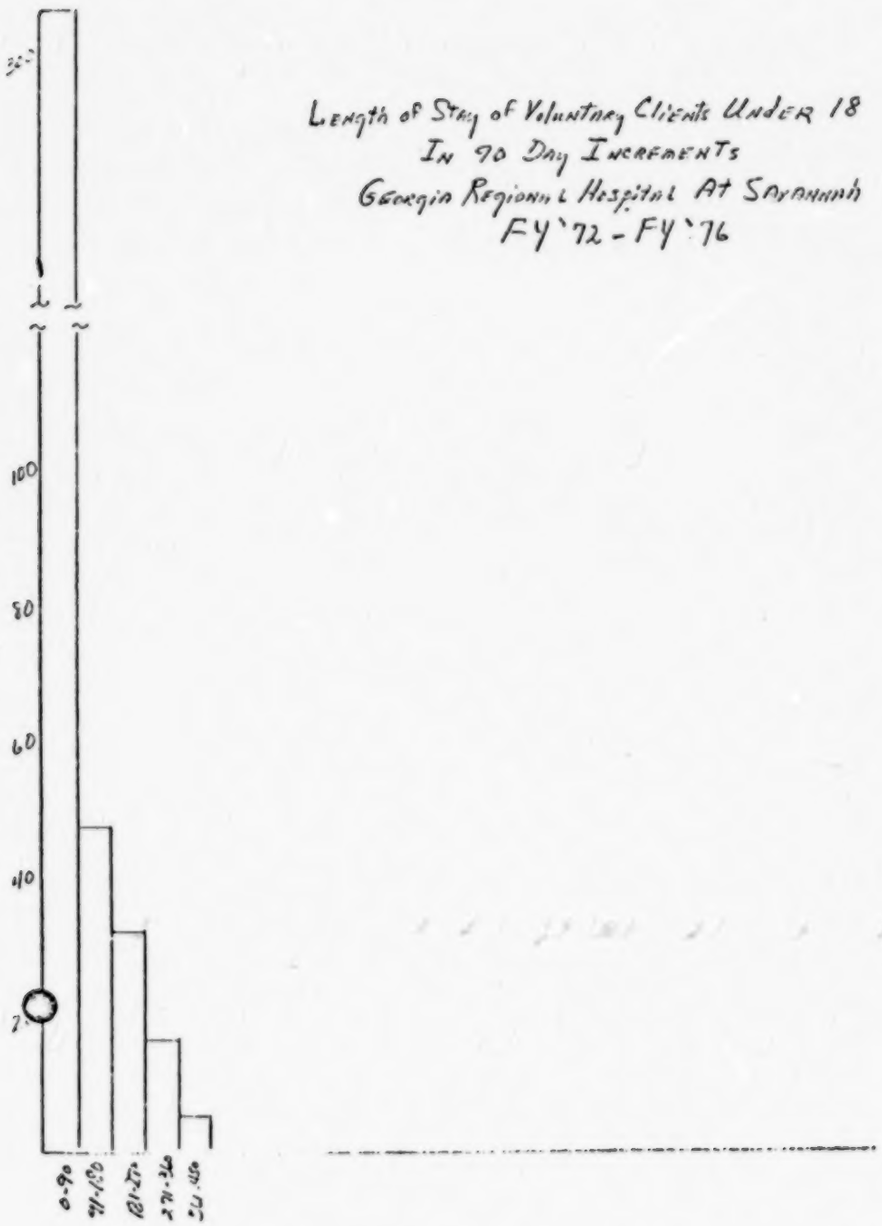
Ga. Regional Hospital at Savannah

	Voluntary Number	%	Involuntary Number	%
Total	407	66%	241	34%
FY 69				
FY 70				
FY 71				
FY 72	70	78%	20	22%
FY 73	148	69%	66	31%
FY 74	122	65%	65	35%
FY 75	54	41%	76	59%
FY 76	13	48%	14	52%

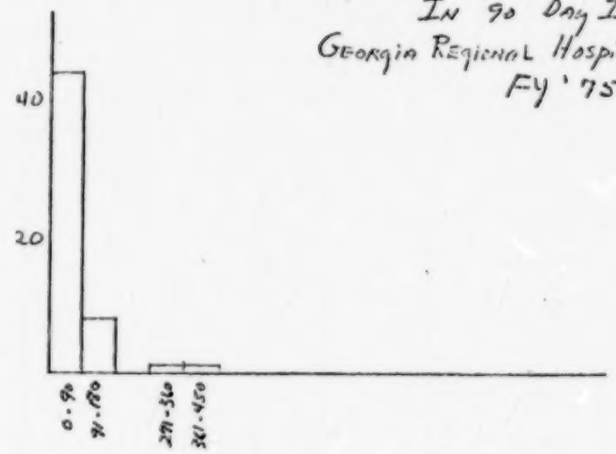
Length of Stay of Voluntary Clients Under 18
Discharged Within 2 Years After Admission
In 30 Day Increments
Georgia Regional Hospital AT Savannah
FY '72 - FY '76



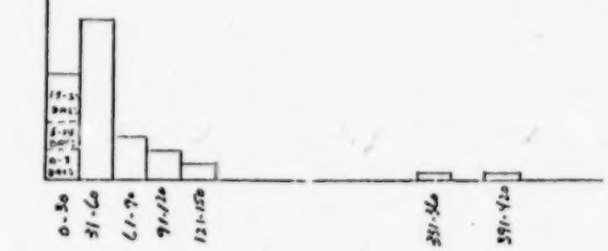
Length of Stay of Voluntary Clients Under 18
In 90 Day Increments
Georgia Regional Hospital At Savannah
FY '72 - FY '76



Length of Stay of Voluntary Clients Under 18
In 90 Day Increments
Georgia Regional Hospital At Savannah
FY '75



Length of Stay of Voluntary Clients Under 18
Discharged Within 2 Years After Admission
In 30 Day Increments
Georgia Regional Hospital At Savannah
FY '75



Length of Stay of Voluntary Clients
Under 18: 30 Day Sample
Georgia Regional Hospital at Savannah

Days	# of Clts	Days	# of Clts	Days
0 - 30	148	721 - 750		1441 - 1470
31 - 60	114	751 - 780		1471 - 1500
61 - 90	45	781 - 810		
91 - 120	22	811 - 840		
121 - 150	16	841 - 870		
151 - 180	9	871 - 900		
181 - 210	16	901 - 930		
211 - 240	9	931 - 960		
241 - 270	7	961 - 990		
271 - 300	3	991 - 1020		
301 - 330	6	1021 - 1050		
331 - 360	7	1051 - 1080		
361 - 390	2	1081 - 1110		
391 - 420	1	1111 - 1140		
421 - 450	2	1141 - 1170		
451 - 480		1171 - 1200		
481 - 510		1201 - 1230		
511 - 540		1231 1260		
541 - 570		1261 - 1290		
571 - 600		1291 - 1320		
601 - 630		1321 - 1350		
631 - 660		1351 - 1380		
661 - 690		1381 - 1410		
691 - 720		1411 - 1440		

Length of Stay by Voluntarily Admitted Clients Under 18 Receiving
Mental Health Services by Fiscal Year of Discharge
West Central Ga. Regional Hospital

	Days				Months				
	0-7	8-14	15-30	31-60	61-90	0-3	4-6	7-9	10-12	13-15	16-18	20-21	22-24	Over 2 Yrs
Total	1	1	3	2	1	8	3							
FY 69														
FY 70														
FY 71														
FY 72														
FY 73										3				
FY 74			1	1										
FY 75	1													
FY 76		1	2	1	1	5	3							

* Blanks were compiled on basis of 30 days per month.

Number and Percent of Voluntary and Involuntary Admissions
Of Clients Under 18 in Mental Health Services
by Fiscal Year of Admission

West Central Ga. Regional Hospital

	Voluntary Number	%	Involuntary Number	%
Total	27		6	
FY 69				
FY 70				
FY 71				
FY 72				
FY 73				
FY 74				
FY 75	7	53%	6	47%
FY 76	20	100%	-	-

IN THE UNITED STATES DISTRICT COURT
MIDDLE OF DISTRICT OF GEORIGA
MACON DIVISION

J. L. and J. R., minors, individually and on behalf of all others similarly situated,

Plaintiffs,

v. CIVIL ACTION NO. 75-163-MAC

JAMES PARHAM, individually and as Commissioner of the Department of Human Resources; DOUGLAS SKELTON, individually and as Director of the Division of Mental Health; W. T. SMITH, individually and as Chief Medical Officer of Central State Hospital,

Defendants.

AFFIDAVIT

Personally appeared before me, the undersigned officer, duly authorized to administer oaths, Cynthia Arnold, who states upon oath as follows:

1.

I am Cynthia Arnold, a secretary for the Division of Mental Health and Mental Retardation, Department of Human Resources.

2.

I make this affidavit on personal knowledge and for use by the Defendants in the above-styled civil action.

3.

The information in the attached exhibits was given to me by telephone by the personnel at the regional hospitals and typed therefrom, except that the information on minors at Central State Hospital was supplied directly by the Hospital.

Appendix C

This 16th day of December, 1975.

Cynthia Arnold

Cynthia Arnold

Sworn to and subscribed
before me this 16th day
of December, 1975.

Carolyn J Peoples
Notary Public
Notary Public, Georgia State at Large
My Commission Expires April 23, 1979

Patients Released Vol. Patients less than 18 years of age in Mental

Hospital for N.P. Chisel on October 31, 1975. INPATIENT

Name	Birthdate	Adm. Date	Person or Agency Requesting Admission	Diagnosis (By name not code)	Expected or actual Date of Release
[illegible]	10/28/57	10/26/75	Self	Schizo. Chronic Undifferentiated Type	11/20/75
[illegible]	10/22/57	8/13/75	Parent	Schizo. Chronic Undifferentiated Type	2/18/76
[illegible]	11/24/57	10/11/75	Self	Hysterical Personality	Outpatient status - 11/13/75 Transferred to C.S.E. 12/10/75
[illegible]	11/15/57	10/27/75	Parent	Drug Abuse, Schizo. Chronic Undifferentiated Type	11/3/75
[illegible]	5/7/62	10/22/75	Parent	Mild Retardation	11/17/75
[illegible]	7/24/58	10/14/75	Self	Mild Mental Retardation	2/18/76
[illegible]	3/26/64	4/30/75	Parent	Adjustment Reaction to Childhood	Unknown - probably never discharged.
[illegible]	11/24/58	7/14/75	Parent	Schizo. Chronic Undifferentiated Type	1/3/76
[illegible]	8/9/65	10/15/75	Parent	Schizo. Chronic Undifferentiated Type	12/12/75
[illegible]	12/24/62	12/2/74	Parent	Childhood Schizo.	1/18/76

[illegible] Atlanta Regional Vol. Patients less than 18 years of age in Mental Hospitals (not M.R. Units) on October 31, 1975. INPATIENTS.

Client Initials	Birthdate	Adm. Date	Person or Agency Requesting Admission	Diagnosis (By name not code)	Expected or actual Date of Release
B.	3/24/55	5/7/74	Parent	Runaway Reaction	6/18/76
[illegible].	6/9/57	9/8/75	Self	Schizo. Acute with Depression	11/5/75
[illegible].	7/3/59	9/4/75	Parent	Explosive Personality	12/17/75-Daypatient Est. Dis. 1/31/76
[illegible].	10/28/59	10/20/75	Self	Adjustment Reaction to Adolescence	1/3/76
[illegible].	9/[illegible]/57	12/8/73	Self	Drug Abuse & Alcoholism Unspecified	12/8/75
[illegible].	11/23/57	8/31/75	Self	Schizo. Chronic Undifferentiated Type	12/16/75 - Eval. Status
S.	9/24/58	10/27/75	Parent	Marijuana Addiction Drug Abuse, Adjustment Reaction to Adolescence	11/18/75
E.	11/26/57	9/19/75	Self	Moderate Mental Retardation	12/20/75
[illegible].	7/28/53	7/8/75	Parent	Schizo. Paranoid Type	6/18/76
P.	4/2/67	7/19/74	Parent	Hyperkinetic Reaction to Childhood	2/18/76
B	8/31/62	6/10/74	Parent	Childhood Schizo.	6/18/76

872

[illegible] Vol. Patients less than 18 years of age in Mental Hospitals (not M.R. Units) on October 31, 1975. INPATIENTS.

Client Initials	Birthdate	Adm. Date	Person or Agency Requesting Admission	Diagnosis (By name not code)	Expected or actual Date of Release
D.	3/16/62	7/9/74	Parent	Borderline MR	6/18/76
[illegible].	6/7/61	9/29/75	Parent	Drug Dependency Anti-Social Personality	1/26/75 - Daypatient Est. Dis. - 1/31/76
[illegible].	4/13/70	4/21/75	Parent	Schizo. Childhood with Autism	3/18/76
[illegible]	3/21/65	5/19/75	Parent	Childhood Schizo.	4/18/76
[illegible].	5/2/59	8/1/75	Parent	Schizo. Chronic Undifferentiated Type	2/15/76
[illegible].	6/5/59	8/5/75	Parent	Adol. Adjustment Reaction - Probable Learning Disability	Outpatient - 11/4/75 Est. Dis. - 2/12/76
[illegible]	5/17/66	9/23/75	Parent	Hyperkinetic Reaction of Childhood	12/17/75
[illegible].	3/27/61	10/31/75	Parent	Adjustment Reaction of Childhood & Hysterical Personality	11/3/75
[illegible].	3/8/62	7/9/75	Parent	Non-psycotic Brain Syndrome w/epilepsy Mild Mental Retardation and Unsocialized Aggr. Reaction	11/7/75
[illegible].	7/[illegible]/61	10/13/75	Parent	Schizo. Schizo-Affective Type	11/6/75

873

...Atlanta Regional Vol. Patients less than 18 years of age in Mental ...tals (non M.R. Units) on October 31, 1975. INPATIENTS.

...t ...ls	Birthdate	Adm. Date	Person or Agency Requesting Admission	-Diagnosis (By name not code)	Expected or actual Date of Release
. B.	12/15/67	10/14/75	Parent	Unsocialized Aggr. Reaction to Childhood	1/18/76
. C.	2/1/62	10/22/75	Parent	Unsocialized Aggr. Reaction to Adol., Mild MR	1/12/76
. .	11/12/59	10/24/75	Parent	Hysterical Personality and Adjustment Reaction to Adolescence	11/24/75
. E.	12/1/54	10/27/75	Parent	Hyperkinetic Reaction to Childhood	1/18/76

874

...Augusta Regional Vol. Patients less than 18 years of age in Mental ...tals (non M.R. Units) on October 31, 1975. INPATIENTS.

...t ...ls	Birthdate	Adm. Date	Person or Agency Requesting Admission	Diagnosis (By name not code)	Expected or actual Date of Release
. .	7/2/57	10/29/75	Ft. Gordon Psychologist (Self)	Depressive Neurosis Hysperical Personality	12/8/75
.B.B.	2/25/59	6/2/75	Augusta M. H. Clinic (Mother)	Schizo. Childhood	5/15/76
..B.	6/26/62	12/29/75	Med. College of Georgia (Mother)	Depressive Neurosis	12/19/75
.B.C.	5/11/60	9/23/75	Comm. M.H. Outpatient Agency (Mother)	Adjustment Reac. to Adolescence	5/15/76
.B.H.	7/12/59	10/15/75	University Hospital (Mother)	Moderate MR	11/19/75
.B.J.	4/8/63	5/5/75	Richmond Cty. Health Dept. (Mother)	Adjustment Reac. of Childhood	1/15/76
.E.B.	8/29/57	10/20/75	Self	Alcoholism	12/2/75
.E.E.	6/6/59	10/8/75	Gracewood School & Hospital (Mother)	Moderate MR Adjustment Reac. of Adolescence	11/9/75
.E.P.	5/18/61	8/26/75	Not in Records	Adjustment Reac. to Adolescence	12/12/75
.F.B.	1/16/61	10/27/75	Outpatient Clinic-McDuffey Cty. (Mother)	Adjustment Reac. to Adolescence	11/10/75

875

...ta Regional Vol. Patients less than 18 years of age in Mental

...als (not M.R. Units) on October 31, 1975. INPATIENTS.

Patient Initials	Birthdate	Adm. Date	Person or Agency Requesting Admission	Diagnosis (By name not code)	Expected or actual Date of Release
[illegible]	11/19/67	10/6/75	Comm. M.H. Out-patient (Mother)	Adjustment Reac. to Childhood	12/12/75
[illegible]	4/3/68	9/3/75	Dr. Clarke (father)	Adjustment Reac. to Childhood	2/1/76
[illegible]	12/17/66	3/24/75	Augusta M.H. Clinic (Father)	Childhood Schizo.	5/15/76 - will be put on day patient
[illegible]	10/8/63	10/14/75	Griffin Cty. Out-patient Clinic (Father)	Adjustment Reac. to Adol.	11/21/75
[illegible]	9/1/60	10/24/75	Augusta Area MH Clinic (Mother)	Adjustment Reac. to Adolescence	11/14/75

876

...avannah Regional Vol. Patients less than 18 years of age in Mental

...tals (not M.R. Units) on October 31, 1975. INPATIENTS.

Patient Initials	Birthdate	Adm. Date	Person or Agency Requesting Admission	Diagnosis (By name not code)	Expected or actual Date of Release
[illegible]	10/1/61	10/21/75	Private Physician (Mother)	Drug Abuse Unspecified	11/15/75 - Discharged
[illegible]	5/29/60	10/24/75	DFCS-Darien Cty. (Guardian)	Adjustment Reaction	12/15/75 - Discharged
[illegible]	1/5/64	10/29/75	Private Psychiatrist (Mother)	Mild Mental Retardation	12/12/75 - Discharged
[illegible]	8/5/60	7/2/75	Gracewood School & Hospital (Mother)	Schizo. Childhood Type	Expected to be discharged within 30 days
[illegible]	11/9/59	2/28/74	Central State (Mother)	Schizo. Childhood Type	Discharge date undetermined
[illegible]	12/9/65	4/11/75	Private Psychiatrist (Father)	Unsocialized Agg. Reaction	11/26/75 - Discharged
[illegible]	3/10/60	9/13/75	Private Physician (Mother)	Acute Schizo. Episode	11/26/75 - Discharged
[illegible]	11/11/61	5/7/75	DFCS - Bulloch Cty. (Guardian)	Unsocialized Agg. Reaction	Discharge date undetermined
[illegible]	7/6/60	9/24/75	Family (Mother)	Schizo. Unspecified Type	Expected to be discharged within 30 days
[illegible]	6/2/59	7/7/75	Bryan Cty. M. H. Clinic (Mother)	Borderline MR	Expected to be discharged within 30 days
[illegible]	9/16/59	9/2/75	Liberty Cty. Court of Ordinary (Mother)	Schizo. Childhood Type	11/21/75 - Discharged
[illegible]	10/7/61	10/6/75	Ft. Stewart Out-patient Clinic (Mother)	Adjustment Reaction	Discharge expected within 30 days

877

[illegible] Bay Arbor Regional Vol. Patients less than 18 years of age in Mental [illegible] (not M.R. Units) on October 31, 1975. INPATIENTS.

Patient Initials	BirthDate	Adm. Date	Person or Agency Requesting Admission	Diagnosis (By name not code)	Expected or actual Date of Release
T. A.	9/26/60	10/21/75	DFCS-Wayne Cty. (Mother)	Unsocialized Agg. Reaction	11/21/75
T. B.	10/1/61	10/21/75	Private Physician (Mother)	Acute Schizo. Episode	Discharge expected within 30 days
D. Y.	4/6/63	10/31/75	Family (Mother)	Hyperkinetic Reaction	Discharge expected within 30 days
T. S.	10/26/71	10/31/75	Hinesville M. H. Clinic (Grandmother Guardian)	Non-psycotic Organic Brain Syndrome Due to Brain Trauma	11/15/75

878

[illegible] Bay Arbor Regional Vol. Patients less than 18 years of age in Mental [illegible] (not M.R. Units) on October 31, 1975. INPATIENTS.

Patient Initials	Birthdate	Adm. Date	Person or Agency Requesting Admission	Diagnosis (By name not code)	Expected or actual Date of Release
[illegible]	12/17/59	9/24/74	DFCS	Hebephrenic Schizo.	12/1/75
[illegible]	2/14/61	9/15/75	Parents	Unsoc. Aggr. Reac. to Childhood	
[illegible]	12/19/63	9/27/75	Mother	Episodic Rage Reac.	12/6/75
[illegible]	5/19/64	9/11/75	DFCS	Unsoc. Aggr. R. of Childhood	12/11/75
[illegible]	2/15/62	9/22/75	Parents	Unsoc. Aggr. R. of Adoles.	12/19/75
[illegible]	8/7/65	10/6/75	DFCS	Unsoc. Aggr. R. Of Childhood	
[illegible]	11/29/61	10/9/75	DFCS	2 Mod. Mental Retardation, Unsoc. Aggr. R. of Adol.	12/19/75
[illegible]	10/1/60	10/15/75	Mother	Hysterical Neurosis w/convulsive Reac.	11/31/75
[illegible]	1/17/63	10/27/75	Mother	Hysterical Neurosis w/convulsive Reac.	11/14/75
[illegible]	4/22/58	10/29/75		Alcohol Addiction Drug Dependence Anti-Social Personality	12/2/75

879

[illegible] Vol. Patients less than 18 years of age in Mental

[illegible] (Unit M.R. Units) on October 31, 1975. INPATIENTS.

Pt. Initials	Birthdate	Adm. Date	Person or Agency Requesting Admission	Diagnosis (By name not code)	Expected or actual Date of Release
[illegible]	3/7/59	10/16/75	Father	Depressive Neurosis Rule out Drug Dependency, Adjustment Reac. to Adol.	11/4/75
[illegible]	11/1/58	10/14/75	Father	Acute Depression & Drug Overdose	2 - 4 mos.
[illegible]	3/6/59	10/18/75	Mother	Adjustment Reac. to Adolescence	1 month - waiting for placement
[illegible]	5/7/61	8/17/72	Father	Childhood Autism	Indefinite (no other facility appropriate
[illegible]	4/27/56	8/6/73	Father	Moderate MR	Impossible to predict
[illegible]	11/26/62	7/30/74	Mother	Psycotic Org. brain syndrome, blindness, MR	March - Academy for Blind
[illegible]	5/3/61	7/14/72	Mother	Borderline Psycotic	1 year at least
[illegible]	10/31/62	7/18/73	Caseworker DPCS	Moderate to mild retardation Unsoc. Aggr. Type	11/13/75
[illegible]	1/24/59	10/30/75	Mother	Extreme family conflict - Hysterical personality disorder	12/16/75
[illegible]	2/[illegible]/5	11/26/73	Father	Hyperkinesis & Min. brain disfunction	January, 1976

[illegible] Vol. Patients less than 18 years of age in Mental

[illegible] (Unit M.R. Units) on October 31, 1975. INPATIENTS.

Pt. Initials	Birthdate	Adm. Date	Person or Agency Requesting Admission	Diagnosis (By name not code)	Expected or actual Date of Release
[illegible]	5/18/62	1/31/74	Brought in by parents - signed in by caseworker	MR, Unsoc. Aggr. Reaction to Childhood	February, 1976
[illegible]	1/26/62	5/1/74	Father	MR, Child Schizo.	6/76
[illegible]	3/28/64	6/4/74	Stepmother	Character Disorder	Impossible to predict Within 6 months
[illegible]	5/21/62	10/24/75	Mother	Unsoc. Agg. Reac.	Anytime - waiting for placement
[illegible]	6/9/58	8/22/74	Mother	Schizo. Undetermined type	12/5/75
[illegible]	11/8/63	6/5/75	Mother	Adjustment Reac. of Childhood	End of May to Group Home if available
[illegible]	12/29/65	4/22/75	Caseworker	Unsoc. Agg. Reac. to Childhood	End of Feb. to Group Home
[illegible]	4/3/63	10/14/75	Mother	Depression, Suicidal ideations	Unknown, waiting for placement, Approx. 2 mos.
[illegible]	6/24/65	7/7/75	Mother	Schizo. Reac. of Childhood	1/76
[illegible]	1/31/59	9/9/75	Mother	Adol. Adjustment Reaction, Schizo. personality	12/19/75
[illegible]	7/29/65	9/22/75	Mother	Childhood Schizo	End of Jan. 1976
[illegible]	11/1/64	9/24/75	Mother	Rule out Psychosis with strong overtones	February, 1976

[redacted] Vol. Patients less than 18 years of age in Mental Hospitals (Not M.R. Units) on October 31, 1975. INPATIENTS.

Patient Initials	Birthdate	Adm. Date	Person or Agency Requesting Admission	Diagnosis (By name not code)	Expected or actual Date of Release
T. T. S.	2/16/58	10/9/75	Mother	Depressive Neurosis & Mild MR	11/13/75
T. D. C.	5/18/67	10/20/75	Mother	Hyperkinetic Reac. of Childhood	January, 1976
T. D. S.	10/24/65	10/23/75	Father	Withdrawing Reac. of Childhood, Hyperkinetic Reac. of Childhood, Cerebral paralysis, Blindness	11/24/75
T. D. B.	12/18/60	10/23/75	Father	Rule out MR	11/17/75

882

-1-

PATIENT'S INITIALS	BIRTH-DATE	ADMISSION DATE	PERSON OR AGENCY REFERRING PATIENT TO HOSPITAL	DIAGNOSIS	EXPECTED OR ACTUAL DATE OF RELEASE
[redacted]	10-03-63	5-19-70	Parents	On Adm: Hyperkinetic Reaction Now: Hyperkinetic Reaction	Impossible to predict
[redacted]	8-00-62	6-25-70	Stephens County DFCS	On Adm: Emotionally Disturbed Now: Unsocialized Aggressive Reaction	Impossible to predict.
[redacted]	10-28-61	1-7-72	Local Health Dept.	On Adm: Unsocialized Aggressive Reaction of childhood, Borderline Mental Retardation. Now: Unsocialized Aggressive Reaction	Discharged 12-2-75
[redacted]	11-13-57	2-1-72	Trans	On Adm: Schizophrenia, Chronic Undifferentiated Type. Now: Schizophrenia, Chronic Undifferentiated Type.	Long term hospitalization, no immediate plans for release
[redacted]	7-1-63	10-5-72	Floyd County DFCS	On Adm: Adjustment Reaction of Childhood. Now: Over anxious reaction of childhood, adjustment reaction of childhood	Impossible to predict
[redacted]	4-1-59	2-5-73	Bibb County DFCS	On Adm: Adjustment Reaction of adolescence. Now: Adjustment Reaction of adolescence.	Two months
[redacted]	3-4-61	2-21-73	Private Physician	On Adm: Adjustment Reaction of childhood, Psychomotor Epilepsy Now: Organic Brain Syndrome, Brain Trauma	If Day Program opens in Houston County, he will be discharged
[redacted]	3-18-58	10-1-75	Mother	On Adm: Schizophrenic, Acute Type Now: Schizophrenic, Chronic Undifferentiated Type.	Anytime on temporary visit

883

PATIENT'S INITIALS	BIRTH-DATE	ADMISSION DATE	PERSON OR AGENCY REFERRING PATIENT TO HOSPITAL	DIAGNOSIS	EXPECTED OR ACTUAL DATE OF RELEASE
J.F.W.	2-27-65	8-14-73	Family	On Adm: Adjustment reaction of childhood. Now: Adjustment Reaction of childhood	Should be if father appears.
J.M.W.	12-20-57	9-20-73	Crisp County DFCS	On Adm: Adjustment Reaction of adolescence. Now: Depressive Neurosis, Unsocialized Aggressive Reaction Adolescence	Three weeks.
T.M.B.	11-7-58	5-20-74	Gracewood State Hospital	On Adm: Mental Retardation, moderate with unknown prenatal influence Now: Mental Retardation, moderate with unknown prenatal influence	Psychotic - when condition improves may be transferred to Developmental Disability Center or Gracewood, probably never function outside Hosp, with major psychiatric disorder.
T.W.P.	9-25-63	6-13-74	Family	On Adm: Deferred Now: Unsocialized Aggressive reaction, acute schizophrenic episodes	Not yet
G.V.H.	9-10-64	7-16-74	Thomas County DFCS	On Adm: Adjustment reaction Now: Unsocialized Aggressive Reaction	Transferred to Southwestern State Hospital 12-17-75
J.D.	10-21-61	7-31-74	Putnam County DFCS	On Adm: Reaction of adolescence Now: Adjustment reaction of adolescence, Borderline Mental Retardation with an unspecified condition	Discharged 12-8-75 Readmitted 12-17-75
D.M.D.	12-2-57	1-23-75	Central State Hospital Police	On Adm: Borderline Mental Retardation Now: Mental Retardation border with infection	Impossible to predict.
T.H.	5-14-58	3-17-75	Mother	On Adm: Adjustment Reaction of Adolescence. Now: Schizophrenia, latent type	Three months
J.F.M.	5-23-58	12-9-74	Whitfield County DFCS	On Adm: Deferred Now: Adjustment Reaction of Adolescence Schizophrenia, Paranoid Type by history to be ruled out.	Thirty days.

884

PATIENT'S INITIALS	BIRTH-DATE	ADMISSION DATE	PERSON OR AGENCY REFERRING PATIENT TO HOSPITAL	DIAGNOSIS	EXPECTED OR ACTUAL DATE OF RELEASE
J.L.B.	1-6-61	3-11-75	Floyd County DFCS	On Adm: Unsocialized aggressive reaction of childhood Now: Adjustment reaction of adolescence	Will be discharged upon return from Christmas
G.H.	2-21-68	4-2-75	Mother	On Adm: Behavior disorder of childhood, hyperkinetic reaction,R/O Organic Brain Syndrome associated with other physical condition Now: Organic Brain Syndrome, Intracranial Infection	Will be discharged 12-19-75
L.B.J.	11-23-60	6-20-75	Mother	On Adm: Adjustment Reaction to adolescence Now: Adjustment Reaction of adolescence, Runaway reaction of adolescence	Discharged 11-19-75
M.D.S.	11-29-59	6-24-75	Caseworker, DFCS	On Adm: Explosive Personality (Epilipetoid Personality Disorder) Now: Explosive personality	Impossible to predict.
F.P.	11-7-67	7-11-75	Bibb County DFCS	On Adm: Rule out overanxious reaction, Adjusted reaction to childhood Now: Adjusted reaction of childhood, Childhood schizophrenia	Discharged 11-6-75
P.L.P.	11-30-59	7-31-75	Georgia Baptist Children's Home	On Adm: Adjusted reaction of adolescent Now: Adjustment reaction of adolescent	Discharged 11-13-75
D.G.	1-13-61	8-8-75	Fulton DFCS	On Adm: Explosive personality, Adjustment Reaction of adolescence Now: Adjustment reaction of adolescence	Discharged 12-17-75
D.K.C.	2-7-62	8-13-75	Mother & Health Department	On Adm: Schizophrenia, acute episode Now: Hysterical neurosis, Conversion type.	Pending notice of transfer to Tulnadge

885

	PATIENT'S INITIALS	BIRTH-DATE	ADMISSION DATE	PERSON OR AGENCY REFERRING PATIENT TO HOSPITAL	DIAGNOSIS	EXPECTED OR ACTUAL DATE OF RELEASE
59	A.C.R.	1-20-61	8-26-75	Mother	On Adm: Mild Mental retardation Now: Mental Retardation, Mild with other condition.	To be discharged 12-20-75
35	G.C.	4-19-56	9-5-75	Vocational Rehab.	On Adm: Depressive Neurosis, explosive personality Now: Non-psychotic CBS due to brain trauma	June 1976
74	J.C.C.	8-26-61	9-8-75	Mental Health Center Dr. Jim Kirby, Psy. Warner Robins Mental Health Center	On Adm: Mild Mental Retardation, rule out accompying major psychotic disorders Now: Mental Retardation, mild with unknown prenatal influence	Extended treatment planned Not ready to be released Impossible to predict.
14	L.D.	4-7-61	9-12-75	Family	On Adm: Schizophrenia, Hebephrenic Now: Schizophrenia, Hebephrenic	Discharged 12-4-75
2	M.E.L.	2-23-63	9-15-75	Court Social Worker & Mother	On Adm: Alcoholism, alcohol addiction Depressive reaction Now: Unsocialized agressive reaction	Court will take her as soon as psychological is done
3	J.S.	1-27-60	9-22-75	Father	On Adm: Mild Mental Retardation Adjustment reaction of adolescence Rule out psychomotor seizures Now: Mental Retardation Mild, with unknown prenatal influence	Discharged 11-17-75
2	S.H.	4-1-61	9-24-75	DFCS	On Adm: Schizophrenia, paranoid type hallucenatory Now: Adjustment reaction of adolescence	Discharged A.M.A. 12-4-75
1	W.H.	9-20-59	9-25-75	Parents	On Adm: Non psychotic CBS Now: Hysterical neurosis conversion type	Three months - Temporary visit within period.
[illegible]	W.F.M.	7-17-65	10-6-75	Father	On Adm: Non psychotic CBS with epilepsy Now: Non psychotic CBS with epilepsy	Discharged 12-10-75

888

	PATIENT'S INITIALS	BIRTH-DATE	ADMISSION DATE	PERSON OR AGENCY REFERRING PATIENT TO HOSPITAL	DIAGNOSIS	EXPECTED OR ACTUAL DATE OF RELEASE
1	L.C.	9-10-61	10-14-75	Mother	On Adm: Deferred Now: Mild Mental Retardation due to unknown prenatal influence	Discharged 11-6-75
1	K.P.C.	6-23-63	10-17-75	Parents	On Adm: Adjustment reaction of adolescence Now: Hyperkinetic reaction of adolescence	Impossible to predict.

887

ATTACHMENT "A"

To Post-Discovery Brief of Plaintiffs

HOSPITAL	MENTAL RETARDATION GROUP I 310-315	ORGANIC BRAIN SYNDROMES GROUP II 290.0-294.8 309.0-309.9	PSYCHOSES NOT ATTRIBUTED TO PHYSICAL CONDITIONS GROUP III 295.0-298.0
SOUTHWESTERN ALOS 100	1. 70		1. 397
CENTRAL STATE ALOS 456	2. 1423 3. 114 4. 97 5. 55 6. 22 7. 61 8. 330 9. 570	1. 1024 2. 257 3. 66 4. 64	2. 115 3. 88 4. 90
ATLANTA REGIONAL ALOS 161	1. 25 2. 61 3. 100		1. 24 2. 122 3. 6 4. 151 5. 60 6. 379 7. 97 8. 105 9. 157 10. 185
G.M.H.I. ALOS 346	4. 859 5. 857 6. 24	1. 1215 2. 500	11. 1244 12. 589 13. 468 14. 158 15. 100 16. 83 17. 81
AUGUSTA REGIONAL ALOS 92	7. 34 8. 67		18. 193 19. 261
SAVANNAH REGIONAL ALOS 127	9. 43 10. 158	1. 15	20. 163 21. 665 22. 103 23. 111 24. 79 25. 54
WEST CENTRAL ALOS 71	11. 179	2. 28	26. 38 27. 38 28. 32 29. 65
TOTALS	20/5149=257	8/3169=396	33/6501=197

(ALOS = Average Length of Stay)

State-wide ALOS = 140/34988 = 249.4 days
Without Group I = 248.6 days

NEUROSES GROUP IV 300.0-300.8	PERSONALITY DISORDERS GROUP V 301.0-304.8	PSYCHOPHYSIOLOGIC DISORDERS GROUP VI 305.0-305.9	SPECIAL SYMPTOMS GROUP VII 306.0-306.9
1. 45 2. 17	1. 32		
3. 105	2. 124 3. 1414 4. 77		
	1. 30 2. 103 3. 730 4. 22		
1. 18 2. 60 3. 60 4. 34	5. 46 6. 556		
5. 34	7. 42		
	8. 24		
6. 106 7. 26	9. 172		
10/510=51	13/3372=259	0	0

TRANSIENT SITUATIONAL DISTURBANCES	BEHAVIOR DISORDERS OF CHILDHOOD AND ADOLESCENCE	CONDITIONS WITHOUT MANIFEST PSYCHIATRIC DISORDER	NON-DIAGNOSTIC TERMS FOR ADMINISTRATIVE USE
GROUP VIII	GROUP IX	GROUP X	GROUP XI
307.0-307.4	308.0-308.9	316.0-316.9	319.0-319.3
1. 99	1. 90 2. 90 3. 88 4. 70		
2. 850 9. 375 3. 493 10. 272 4. 255 11. 818 5. 151 12. 945 6. 103 7. 127 9. 60	5. 2035 6. 1998 7. 1165 8. 547 9. 515 10. 76 11. 258		
1. 225 2. 60	1. 583 2. 150		
3. 56 4. 190 5. 233	3. 749 4. 680 5. 51 6. 55 7. 31		
6. 85 7. 220 8. 106 9. 13 0. 66 1. 105 . 37 . 20			
4. 51 5. 69	8. 225 9. 218 10. 30 11. 44		
. 184 7. 93 . 69 . 25 . 14 . 12	12. 58		
/6481=196	23/9806=426	0	0

126 MENTAL DISORDERS

TABLE 1

List of DSM-II Diagnoses and Code Numbers†

I MENTAL RETARDATION
- 310. Borderline
- 311. Mild
- 312. Moderate
- 313. Severe
- 314. Profound
- 315. Unspecified

With each: Following or associated with
- .0 Infection or intoxication
- .1 Trauma or physical agent
- .2 Disorders of metabolism, growth, or nutrition
- .3 Gross brain disease (postnatal)
- .4 Unknown prenatal influence
- .5 Chromosomal abnormality
- .6 Prematurity
- * .7 Major psychiatric disorder
- * .8 Psycho-social (environmental) deprivation
- .9 Other condition

II ORGANIC BRAIN SYNDROMES (OBS)

A PSYCHOSES

Senile and pre-senile dementia
- 290.0 Senile dementia
- 290.1 Pre-senile dementia

Alcoholic psychosis
- * 291.0 Delirium tremens
- * 291.1 Korsakov's psychosis
- * 291.2 Other alcoholic hallucinosis
- * 291.3 Alcohol paranoid state
- * 291.4* Acute alcohol intoxication*
- * 291.5* Alcoholic deterioration*
- * 291.6* Pathological intoxication*
- 291.9 Other alcoholic psychosis

Psychosis associated with intracranial infection
- 292.0 General paralysis
- 292.1 Syphilis of CNS
- 292.2 Epidemic encephalitis
- 292.3 Other and unspecified encephalitis
- 292.9 Other intracranial infection

Psychosis associated with other cerebral condition
- 293.0 Cerebral arteriosclerosis
- 293.1 Other cerebrovascular disturbance
- 293.2 Epilepsy
- 293.3 Intracranial neoplasm
- 293.4 Degenerative disease of the CNS
- 293.5 Brain trauma
- 293.9 Other cerebral condition

Psychosis associated with other physical condition
- 294.0 Endocrine disorder
- 294.1 Metabolic and nutritional disorder
- 294.2 Systemic infection
- 294.3 Drug or poison intoxication (other than alcohol)
- * 294.4 Chlor[illegible]
- 294.8 Other and unspecified physical condition

B NON-PSYCHOTIC OBS
- 309.0 Intracranial infection
- * 309.13* Alcohol* (simple drunkenness)
- * 309.14* Other drug, poison or systemic intoxication*
- 309.2 Brain trauma
- 309.3 Circulatory disturbance
- 309.4 Epilepsy
- 309.5 Disturbance of metabolism, growth, or nutrition
- 309.6 Senile or pre-senile brain disease
- 309.7 Intracranial neoplasm
- 309.8 Degenerative disease of the CNS
- 309.9 Other physical condition

III PSYCHOSES NOT ATTRIBUTED TO PHYSICAL CONDITIONS LISTED PREVIOUSLY

Schizophrenia
- 295.0 Simple
- 295.1 Hebephrenic
- 295.2 Catatonic
- * 295.23* Catatonic type, excited*
- * 295.24* Catatonic type, withdrawn*
- 295.3 Paranoid
- * 295.4 Acute schizophrenic episode
- * 295.5 Latent
- 295.6 Residual
- 295.7 Schizo-affective
- * 295.73* Schizo-affective, excited*
- * 295.74* Schizo-affective, depressed*
- 295.8* Childhood*
- 295.90* Chronic undifferentiated*
- 295.99* Other schizophrenia*

Major affective disorders
- 296.0 Involutional melancholia
- 296.1 Manic-depressive illness, manic
- 296.2 Manic-depressive illness, depressed
- 296.3 Manic-depressive illness, circular
- * 296.33* Manic-depressive, circular, manic*
- * 296.34* Manic-depressive, circular, depressed*
- 296.8 Other major affective disorder

Paranoid states
- 297.0 Paranoia
- * 297.1 Involutional paranoid state
- 297.9 Other paranoid state

Other psychoses
- 298.0 Psychotic depressive reaction

IV NEUROSES
- 300.0 Anxiety
- 300.1 Hysterical
- * 300.13* Hysterical, conversion type*
- * 300.14* Hysterical, dissociative type*
- 300.2 Phobic
- 300.3 Obsessive compulsive
- 300.4 Depressive
- * 300.5 Neurasthenic
- * 300.6 Depersonalization
- * 300.7 Hypochondriacal
- 300.8 Other neurosis

TABLE 1 (continued)

V PERSONALITY DISORDERS AND CERTAIN OTHER NON—PSYCHOTIC MENTAL DISORDERS

Personality disorders

301.0 Paranoid
301.1 Cyclothymic
301.2 Schizoid
+ 301.3 Explosive
301.4 Obsessive compulsive
+ 301.5 Hysterical
+ 301.6 Asthenic
301.7 Antisocial
301.81* Passive-aggressive*
301.82* Inadequate*
301.89* Other specified types*

Sexual deviation

+ 302.0 Homosexuality
+ 302.1 Fetishism
+ 302.2 Pedophilia
+ 302.3 Transvestitism
+ 302.4 Exhibitionism
+ 302.5* Voyeurism*
+ 302.6* Sadism*
+ 302.7* Masochism*
302.8 Other sexual deviation

Alcoholism

+ 303.0 Episodic excessive drinking
+ 303.1 Habitual excessive drinking
+ 303.2 Alcohol addiction
303.9 Other alcoholism

Drug dependence

+ 304.0 Opium, opium alkaloids and their derivatives
+ 304.1 Synthetic analgesics with morphine-like effects
+ 304.2 Barbiturates
+ 304.3 Other hypnotics and sedatives or "tranquilizers"
+ 304.4 Cocaine
+ 304.5 Cannabis sativa (hashish, marihuana)
+ 304.6 Other psycho-stimulants
+ 304.7 Hallucinogens
304.8 Other drug dependence

VI PSYCHOPHYSIOLOGIC DISORDERS

305.0 Skin
305.1 Musculoskeletal
305.2 Respiratory
305.3 Cardiovascular
305.4 Hemic and lymphatic
305.5 Gastro-intestinal
305.6 Genito-urinary
305.7 Endocrine
305.8 C f special sense
305.9 C pe

VII SPECIAL SYMPTOMS

306.0 Speech disturbance
306.1 Specific learning disturbance
+ 306.2 Tic
+ 306.3 Other psychomotor disorder
+ 306.4 Disorders of sleep
+ 306.5 Feeding disturbance
306.6 Enuresis
+ 306.7 Encopresis
+ 306.8 Cephalalgia
306.9 Other special symptom

VIII TRANSIENT SITUATIONAL DISTURBANCES

307.0* Adjustment reaction of infancy*
307.1* Adjustment reaction of childhood*
307.2* Adjustment reaction of adolescence*
307.3* Adjustment reaction of adult life*
307.4* Adjustment reaction of late life*

IX BEHAVIOR DISORDERS OF CHILDHOOD AND ADOLESCENCE

+ 308.0* Hyperkinetic reaction*
+ 308.1* Withdrawing reaction*
+ 308.2* Overanxious reaction*
+ 308.3* Runaway reaction*
+ 308.4* Unsocialized aggressive reaction*
+ 308.5* Group delinquent reaction*
308.9* Other reaction*

X CONDITIONS WITHOUT MANIFEST PSYCHIATRIC DISORDER AND NON—SPECIFIC CONDITIONS

Social maladjustment without manifest psychiatric disorder

+ 316.0* Marital maladjustment*
+ 316.1* Social maladjustment*
+ 316.2* Occupational maladjustment*
316.3* Dyssocial behavior*
+ 316.9* Other social maladjustment*

Non-specific conditions

+ 317* Non-specific conditions*

No Mental Disorder

+ 318* No mental disorder*

XI NON-DIAGNOSTIC TERMS FOR ADMINISTRATIVE USE

319.0* Diagnosis deferred*
319.1* Boarder*
319.2* Experiment only*
319.3* Other*

†Many of the titles here are listed in abbreviated form.
* are new diagnoses, that do not appear in DSM-I.

ATTACHMENT "B"

To Post-Discovery Brief of Plaintiffs

QUESTIONABLE ADMISSIONS: DIGEST OF SELECTED PATIENT ADMISSION NOTES

Pursuant to plaintiff's request for documents and in response to plaintiff's interrogatories, each regional hospital superintendent submitted admission notes and social summaries of the members of plaintiffs' class currently confined in these institutions as exhibits in their respective depositions.

Due to the voluminous nature of these documents the originals were not attached to the depositions filed with the court. Rather the plaintiffs are hereby attaching digests or the summaries referred to in plaintiffs' Post-Discovery Memorandum. The complete summaries are available to the Court and/or the defendants upon request.

QUESTIONABLE ADMISSIONS

232-00-2191 — 14 y/o WM admitted to Savannah Regional on 10-6-75...when pt. 3 y/o tried to choke his brother...hyperactive... talks too much according to mother...masturbates a lot... too affectionate...nervous...father beats pt.'s head against wall and uses cruel and unusual punisment. Impression: For whatever reason, Loren is the scapegoat to the degree that the whole family attitude is detrimental to normal growth and development of the child, and it would certainly seem that placement way from the family is the only hope for Loren to reach any kind of social adjustment. In the background with the father using cruel and unusual punishment, coupled with the lack of love and understanding from other members of the family, the father's preparation to take Loren hunting and teaching him to shoot, could well lead to a family conspiracy of murder through the child.

255-[illegible]-9362 — 11 y/o BM admitted to Savannah Regional on 10-29-75...referred as being hysterical and out of control...mother stated that when pt. was discharged after previous admission, she was unable to get the medication and pt. was off the medicine until 4-5 months ago...medicine prescribed by Dr. Tillinger caused vomiting and headaches...pt. referred to in the community as the "little preacher" because of his preaching and shouting ...goes to the Holiness Church...states he likes to tease people and tell them he sees things and ringing and shouting ...mother does not see his behavior as so destructive...no indication of psychosis since admission but he often tells "tall tales" and gets into minor mischief.

832-00-2238 — 15 y/o BF admitted to Savannah REgional on 11-14-75...apparently attempted suicide by swallowing an unknown number of pills... 2 suicide notes, one in verse, other to mother...pt. has run away from home 6 times...mother filed unruly charge against her...CMH psychiatrist felt mother was distrubed...CMH would accept a referral back for pt. but are not able to come because of work pressure...impression is strong problem lies more with mother and family situation.

832-00-1063 — Female admitted to Savannah Regional on 8-24-75...4th admission...readmitted because of similar past behavior...leaving home without mother's permission, sitting on bridge w/ dress up...calling former male pt. from Ga. Regional, attempting to entice him to have sex and generally out of control of mother ...it was felt at admission pt. was not psychotic...it is definitely impossible for this girl to return home and a placement is the only possible solution although because of her acting out, will be very difficult to find facility agreeable to working w/ her...child and adolescent co-ordinator had been working...to have pt. readmitted to public school... naturally when pt.'s mother readmitted her, these plans went down the drain.

832-00-1766 — 16 y/o BM readmitted to Savannah Regional on 7-22-75...recommendation at time of discharge in May was an alternate home placement, such as foster placement and either vocational training or job corps...this recommendation was not carried thru and pt. was allowed to return home w/ supervision by DFCS and MHC...decision made to readmit for stabilization on medication and evaluation for VR services and placement... because of his mother's inability to relate info correctly, it is not known exactly what pt.'s behavior has been like since his discharge.

260-98-113[illegible] — 14 y/o male readmitted to Savannah Regional on 5-7-75...unmanageable in the foster home...but there was no class in special education available to John. As frustration increased, John became more aggressive, and was suspended from school, and the _____ again asked to have him removed because they were unable to handle him...Impression: This is a boy who was deprived culturally, starved and beaten in his early years, and never received adequate nurturing. He is easily frustrated,

and there has been no special education available to give him more individual training. He is ingratiating with adults, but is unable to make friends with his peer group. Despite this, because he is older, group placement rather than foster home placement is recommended because professional personnel is better equipped to handle his special problems in adjustment.

831-00-1907 — 8 y/o boy admitted to Augusta Regional on 10-27-75...difficulty in school...teacher feels she cannot cope w/ him in the classroom...at times threatened to kill himself and has talked to himself...mother expressed concern that due to his behavior she might hurt him...mother evidences continuous depression... reacts at home, in school and at the babysitter's with verbal hostility and "screaming". He has threatened to kill himself. He has begun to talk aloud saying he is "telling the devil" to leave him alone. After two years of psychiatric treatment, hospitalization was recommended to the mother because of her own difficulties in functioning. She was rejecting of this and has sought no further help for herself.

261-00-2543 — 7 y/o WM admitted to Augusta Regional on 9-22-75...his parent described his behavior as being hyperactive; he was also described as having a short attention span and having easy distractability and having run away. His parents seemed to feel they could not cope with this problem on their own...they requested he be admitted here...when seen, this young boy did not appear particularly hyperactive; however, this is frequently the case during an interview situation...there were no gross signs of psychosis, neurosis, or severe mental retardation.

831-00-3203 — 14 y/o boy admitted to Augusta Regional on 10-8-75...behavior problem...had a history of extreme acting out behavior...was brought to the center after he stole his father's car and wrecked it...has also run away from home on numerous occasions ...has experimented with marijuana on two occasions, but denies any other drug-related problems...patient is alert...is well-mannered and well-dressed...does not seem to be retarded or show signs of organicity...there are no signs of psychosis, severe neurosis...is oriented times time three...there are no signs of mental deficiency...since mon's death, pt. appears bored w/ school and has threatened and angered father...began when father talked about mother and [old times].

261-57-7450 — 16 y/o Male admitted to Augusta Regional on 10-24-75... being mistreated by parents...he has had some difficulty with rebellious behavior...this has consisted of some acting out and hostility toward his stepfather...on the day prior to his admission here, he called the Department of Family and Children Services and requested to talk with a Miss Rivers...he was seen by Miss Rivers who stated he would not return home...he stated his mother had threatened him and that he did not get along well with his stepfather...his mother denied this to our social worker here...rather than go home, he was placed overnight in jail and the next day was seen by a physician who recommended hospitalization...this is a very alert and intelligent young man...he relates in a quite mature manner...there is no evidence of any psychosis or severe depression or any neurosis...there is no evidence of any organicity and certainly no evidence of any mental retardation...this young man's assets come out very strongly in the mental status interview.

251-57-2450 — 13 y/o male admitted to Augusta Regional on 11-11-75...running away from home...pt.'s mother had brought the patient to the CAAP Community Service Center due to what she saw as "homosexual behavior"...he also had nightmares, sleep-walking and episodes of running away from home...his mother felt that when he was in a foster home at age eight, he developed some homosexual attitudes towards males...also he had just recently experienced episodes of running away from, which his mother seemed to feel was secondary to his "homosexuality"...mother seemingly has difficulty maintaining herself, emotionally and financially...the pt. was cooperative and friendly...he was neatly dressed...there was no evidence of delusions or hallucinations or severe depression.

834-00-0227 — 13 y/o WM admitted to W. Central Regional on 11-13-75... admission due to chronic truancy, poor peer relationships and academic failure...speech clear coherent and relevant...no losseness or flight of thoughts...affect of mild depression... no thought disorder detected...no hallucinations...general info very poor...judgement poor insight 0...while sitting "quietly" is in constant motion...MCD w/ reading disability.

834-00-0166 — 9 y/o WM ad-itted to W. Central Regional on 10-6-75...expelled from special classes for uncontrollable behavior...no behavior problems at home...alert cooperative appropriately behaving... good eye contact and sense of humor...no thought disorder... no flights...doesn't know what gets him angry but he does admit to spells of anger

260-21-5860 — 14 y/o BF admitted to W. Central Regional...reported to be aggressive and disruptive in school and plans are afoot to expel her...an alert cooperative adolescent...speech clear, coherent and relevant...no flight or looseness...mild depression...judgment and insight present...due to lack of community resources, referred to hospital.

830-01-4117 — 13 y/o BF admitted to Atlanta Regional on 10-22-75.

253-11-1743 — 17 y/o BF admitted to Atlanta Regional from CSH on 10-14-75.

7 — admitted to GMHI on 10-18-75...admission at this time seems to be related to the great amount of family conflict at home ...no indication of a thought disorder...associations good and memory intact...although talks of suicide, no indications that he actively plans to kill self or make any suicidal attempts at this time...reports no hallucinations.

8 — 15 y/o WF readmitted to GMHI for 5th time on 11-7-75 from devereaux school...CHIEF COMPLAINT: the pt. was brought to the hospital on a friday afternoon at approximately five or six o'clock after a daylong episode of uncontrollable behavior. ..this behavior, including throwing rocks at the treatment home psychiatrist's car, throwing a chair, threats to hurt the staff, demanding behavior and general uncontrollable behavior...the Devereaux School stated they had no absolute security sections and could not contain this type of behavior. the pt. was brought in without the community being notified and the hospital was only notified once the pt. was in transit. the Community was quickly notified. the pt. says she came because she was slapped by a staff member(this probably occurred because of hysterical behavior on the pt.'s part as a way of bringing her back to reality, but this is only speculation) Also there had been a call to her grandparents a day or two before and this had upset the pt. because the grandparents were intoxicated and pt. had called to ask them about a trip to them for Christams. A third factor that may have something to do with the hospitalization involved the therapist on Unit Pt. was aware that this therapist was leaving and that the following week was to be the therapist's final week on the unit. It is a possibility this is a conscious or subconscious attempt to see the therapist before his leaving...this is an institutionalized child who knows all of the institutional ways to express craziness and get need taken care of.

29. — Reason for modality change [hospitalization] is due to fact that father is dying of cancer...grief mom and pt. feel is so upsetting that he can no longer be managed at home...

800-4190-083 — 8 y/o WF admitted to CSH 8-14-73...father states he and his wife have been diforced and his ex-wife was not the best example for the child...she used to live a promiscuous life ...he says he remarried and his daughter was awarded to his father by the court, who died of cancer, and since he has been taking care of the child...she says the child cannot concentrate and it is difficult for her to learn...she is involved in sexual activity with a boy her age, meaning kissing and petting...this upset the whole family...pt. states that she has only one problem, that when she reads a book, she does not read the same as other people do. she says she cannot understand very well...pt. very nervous.

800-201-514 — 11 y/o BM re-admitted to CSH on 1-29-75...mother states that the pt. is practically doing alright at home and his relation w/ the family especially w/ the children is quite excellent ...he also plays in the neighborhood w/out creating any problems...two weeks ago he hit his head against a bookcase sustaining a hematoma on his head...three days afterwards that incident he accidentally poured some battery acid on his thigh causing some ulceration...the day prior to admission he ran into a boy unintentionally or accidentally...he said he never had any quarrels with his fellow classmates, instead he is friendly, but his teacher complained that he is naughty... when asked in what way, he could not answer...pt. is fairly developed, and nourished, conscious, coherent, black male in no acute distress...affect is appropriate.

800-209-668 — 14 y/o BF admitted to CSH on 11-12-75...referred by the Montgomery County DFCS as a result of discovery of a four-year history of incest and charges being brought against the father. has been placed in custody of her real mother whom she has not seen for eleven years...she had difficulty adjusting at school, was suspended for accusing the assistant-principal (of 20 years employment) of kissing her...is manipulative with little self-discipline and is easily led...very cooperative...speech was coherent and relevant...train of thought was logic... affect was appropriate although showed some hostility when asked about her relations with her father...did not elicit any delusional system at the time of the interview...denies hallucinations, illusions or misinterpretations...oriented in all the spheres and memory was good for recent and remote events...has a good fund of general information...has some insight, judgment intact...recommendation: placement in good foster home or group home.

800-193-966 — 15 y/o WM admitted to CSH for 1st admission on 2-5-73...it appears that pt.'s expulsion from school was the precipitating crisis leading to his hospitalization at Central State Hospital ...I find it interesting that pt. and the foster mother were not involved in out-patient treatment at the Bibb Co. Mental Health Clinic during his placement with them...there is a religious fervor about the foster mother that I initially distrust...I can't help but wonder if she feels religion is the cure.

D — 17 y/o WF readmitted to CSH on 11-29-75...argument with her father this morning because she left home yesterday afternoon and she didn't come back until this morning...she admitted some marijuana smoking but only occasionally.

800-209-690 — 16 y/o BM readmitted to CSH on 11-12-75...about 3 or 4 weeks prior to his admission he ran out of medication and his mother stated she was unable to get a new supply...he became angry that they were unable to handle him, called her welfare worker and his readmission here was arranged.

800-209-308 — 12 y/o WM admitted to CSH on 10-17-75...brought here by his mother...pt. has run away from home 4 times...pt. is very upset crying, saying he wants to go home with his mother and to come back in the morning...he said that if he will be forced to stay here she will run away...pt. is alert but uncooperative... speech was coherent and relevant...train of thought was logic... appropriate...did not elicit any delusional system during the interview...denies hallucinations, illusions or misinterpretations...oriented in all the spheres...memory was fair for remote and recent events...has a regular fund of general info... little insight into his problem...judgement seems to be preserved...parents divorced, poor home environment, adolescent turmoil... short term hospitalization, chemotherapy as necessary, melieu therapy, group therapy, school work and recreational activities...a foster placement seems to be indicated for this young pt.

14 y/o WF admitted to CSH 2nd time on 4-1-75...brought in by caseworker for voluntary admission...this pat. was admitted the last time on 1-14-72...discharged 1-30-75 with the diagnosis of unsocialized aggressive reaction of childhood 303.40...pt. states that she wants to come back in this hospital and through her suggestion with her caseworker she was brought in yesterday for readmission...pt. claimed that she ran away from her residence in March around 30 minutes and while on the road was caught by houseparents and brought back.. states that the main reason she ran away is that she does not want to be there because "I am staying with 40 blacks and I am the only white" in that place...all of them are teasing her by calling her a "honkie"...she states also that every time she went out on the basketball court, boys and girls but mostly girls would throw rocks at her...on March 13, 1975, while sleeping she was burned on her left thumb by her roommates with sustained blister on her left thumb...pt. is fairly developed and nourished, conscious, coherent, oriented, very quiet, and presenting no signs of aggressive reaction at this time of admission... Impression: Runaway Reaction of adolescence 308.3

REPORT OF THE STUDY COMMISSION ON MENTAL HEALTH SERVICES FOR CHILDREN AND YOUTH

November 9, 1973

MARY M. WOOD, Ed.D.
Chairman

PART I

THE COMMISSION'S APPROACH TO THE TASK

Recognizing the increased need for children and youth mental health services, the Division of Mental Health has placed a high priority on the development of a comprehensive plan for children and youth mental health programs in Georgia. In order to do this, it was determined that the best way to begin was to survey existing services. A group of consultants with experience in community and institutional mental health programs for children and youth was formed, May 1973. This study commission was asked to survey existing programs, analyze needs and make recommendations for development of comprehensive services.

The commission prepared a 37-page reporting form which was used when the commission visited the child and youth units at each of five state hospitals. On each site visit, this format was used by the members of the commission to gather specific information about the program. Following the visit, a staff assistant compiled [2] the individual reports and returned the document to the Superintendent and Unit Director of each hospital for validation. There, the report was reviewed in detail and information which was inaccurate was corrected. This final report is based primarily upon information gathered during the site visits. Additional and substantiating data has been gathered from the Division of Mental Health, Georgia Department of Human Resources. The hospitals visited were:

Savannah Regional Hospital—May 2, 1973 and August 28, 1973

Central State Hospital —May 3, 1973 and September 10, 1973

Augusta Regional Hospital —June 21, 1973 and September 12, 1973

Georgia Mental Health Institute —July 9, 1973 and October 23, 1973

Georgia Regional Hospital at Atlanta —July 10, 1973 and October 11, 1973

The Southwest Regional Hospital was not visited because of the commission's understanding that no child and youth unit has been developed there. However, it has been reported since that some children and youth are presently served at that institution.

[3]

The appendices of this report contain a summary of strengths and weaknesses of the various hospital programs as judged by the commission members. It is important to emphasize that the hospital personnel and the commission have reflected many of the same concerns. There was near consensus agreement between the personnel and commission on most problem areas.

It will be noted that hospital programs are not identified by name in the summaries. It was the unanimous position of the commission that this report should reflect state-wide program progress, strengths, and weaknesses and should recommend directions for the State towards program improvement. It is not the intent of the report to be critical of individual programs.

The appendices also contain summaries of problems as reported by the personnel of these programs. The commission found that personnel of children and youth pro-

grams are keenly aware of problems and have much to offer in constructive suggestions for program improvements.

The individual hospital reports with recommendations specifically directed toward each hospital have been [4] submitted to the Director, Division of Mental Health, and to the Chief of Developmental Services Section.

In addition to those very specific recommendations for each hospital, the commission is aware of a number of problems and issues which are state-wide in nature. Foremost among these issues are the following:

. . . lack of priority for children's services at all levels of administration (including issues of advocates and autonomy)

. . . admission policies and procedures (including the rights of children)

. . . treatment plans and procedures (including out patient services and documentation for program accountability)

. . . shortages of personnel trained in child and youth services (including issues of child and youth training, job responsibilities of the hospitals for training, and pay scales)

. . . responsibility of a hospital's child and youth unit for community services

. . . patient movement and discharge procedures

. . . physical facilities

. . . ways to monitor, evaluate, and plan for needs of children and youth

In response to these problems, the commission has prepared in Part II, a series of fairly specific recom-[5] mendations which could be implemented this year at no

significant cost increase. It is important to understand that the commission does not offer these as a fully developed program plan for children and youth mental health services. Rather, the recommendations contained in Part II, if implemented this year, would provide for some immediate improvement of current conditions and would provide also for collection of data over the next three years with which more informed decisions and program planning could be made.

Given a three-year planning period in which these short-term recommendations are implemented and results evaluated, the State should be able to develop an adequate, comprehensive state-wide mental health service for children and youth.

Finally, the commission is in agreement that there are certain factors unique to children and youth around which a well-conceived service delivery system should be developed. In reviewing the findings and recommendations in this report, it is suggested that the following seven items be used as reference points in judging the current conditions and determining the unmet needs.

[6]

1. Children and youth are still dependent, living and growing under the auspices of others, dependent upon someone else for their psychological maturation and their material and physical well-being.

   A child is dependent upon someone else for identifying his need for help and in seeking assistance. Therefore, there are no true "voluntary" child admissions, and criteria must be established to protect children from needless institutionalization or from the assumption that every child in crisis needs service at a regional hospital.

2. Because of their dependency, treatment for children is complicated; it involves working with those who are significant to the child. Services at the outpatient level, the day treatment level, and at the inpatient level, all within the same institution and with some overlapping of staff are essential. Continuity of service and continuity over age groups are important goals. Creation of direct services in this manner allows a child to move in and out of particular programs in an institution with which he is familiar and with staff with whom he has established a relationship. And furthermore, he may be able to continue in treatment during difficult transitional periods between childhood and adolescence. Therefore, child treatment requires a variety of rich environmental and psychological alternatives, involving many people and experiences in order to provide a responsive environment.
The costs will be greater than for a system which provides benign custodial care. Also, costs for inpatient mental [7] health treatments for children are higher than costs for adults, nationwide.
3. Children and youth are still developing physically, intellectually, socially, and emotionally. This ongoing maturation dictates that there must be a CONTINUITY OF CARE between their home, school, community, and helping agencies such as hospitals and community-based treatment.
4. Children learn from their environment and adapt themselves to it. Such adaptation usually becomes an integral part of the child's personality. A child institutionalized for long periods of time may learn and assimilate "institutionally appropriate" behavior, which in turn is an additional handicap if he is to return to his normal environment. Therefore, all forms of 24-hour care should simulate a normal childhood environment to the extent possible and should maintain regularly scheduled home visiting from the time of initial admission.

5. While certain children do require long-term institutional care, it is extremely important that they receive continued evaluation and reappraisal so that they can be provided alternative forms of care at an optimal time. Therefore, it is imperative that appropriate discharge placement plans be started at the time of admission; this, of course, presupposes a variety of community facilities.
6. Psychological, emotional, and behavioral problems in children usually produce secondary handicaps and problems if not [8] attended to. Therefore, appropriate responsive services provided at onset will be a good investment in the social, emotional, and economic well-being of our State.
7. Children are the most vulnerable group affected by the crisis of growing cities (e.g., transportation, crime, schools, crowding, job pressures on their parents, elimination of play areas, exposure to many different persons with whom they are not prepared to cope). Therefore, we can expect more and different types of emotional, behavioral, and social problems in city children, suggesting a need for a variety of different services in rural and urban areas.

[9]

PART II

SHORT-TERM RECOMMENDATIONS REQUIRING NO SIGNIFICANT COST INCREASES

The commission suggests that State improvement of mental health services to children and youth is urgently needed. A most conservative estimate is 15,371 seriously emotionally-disturbed children and youth (age 16 or younger) needing special services in Georgia.* It is quite likely that this is the number one health problem in Georgia.

Development of appropriate and adequate services should be based upon professional standards, a State plan, citizen advisory participation, and should reflect unmet needs. However, it is very difficult to estimate the needs of mental health services for children and youth in Georgia for a number of reasons:

1. There are no established State program standards.
2. There is no State plan for mental health services to children and youth. There is no data collection system describing present services for children and youth as a basis for intelligent planning.

[10]

3. There are so few appropriate services that recommendations for length of treatment, required "bed space", and alternative services can only be educated guesses. In most of Georgia, for a disturbed child or youth, there are only two sources of service —a Youth Development Center or a Regional Mental Hospital. It is clear that not all disturbed children benefit from either of these types of programs.

*See Appendix, Figure A-1.

The commission suggests that the task before the State should be viewed in three phases:

Phase I—Implementation of urgently needed improvements during this current Fiscal Year and Fiscal Year 1975 with minimal budget increase.

Phase II—Establishment of a three-year Child and Youth Mental Health Task Force to begin July 1, 1974—with a temporary data collection system to be used as an information-base for comprehensive state-wide planning.

Phase III—Implementation of a state-wide system of services with new, more appropriate alternatives to hospital care to be phased-in with careful cost accounting and man-power training programs over a period of several years, beginning in Fiscal Year 1975.

The following recommendations have been prepared by the commission to provide some immediate improvement of current conditions (Phase I) and to initiate a data [11] collection system and program guidelines for beginning Phases II and III.

These recommendations are not all-inclusive, but they reflect major problem areas. The recommendations also reflect a deep concern among the commission members that regional hospitals should be regarded as a resource only for children and youth regarded as seriously emotionally-disturbed, in actual need of hospital care, and that these hospital services become part of a comprehensive area-wide program of services.

The commission supports the position of a majority of professionals involved in child and youth treatment that there are many alternative forms of both 24-hour care

and community-based outpatient care which are preferable alternatives to hospitalization yet, which, with a few notable exceptions, do not exist at present in Georgia.

* * * * *

[24]

Variations and alternatives
to hospital care

RECOMMENDATION: 3

IT IS THE OBSERVATION OF BOTH HOSPITAL PERSONNEL AND THE COMMISSION THAT MORE THAN HALF OF THE HOSPITALIZED CHILDREN AND YOUTH WOULD NOT NEED HOSPITALIZATION IF OTHER FORMS OF CARE WERE AVAILABLE IN COMMUNITIES.

Hospital records indicate that between 50 and 75% of the children and youth currently served in these institutions have no family or are part of severely dysfunctional family units or are in State custody. In addition, the commission's findings indicate that more than half of the hospitalized children are characteristically aggressive, anti-social, hyperkinetic, or run-aways and non-psychotic. This suggests that the child and youth populations at the hospitals are in many respects similar to children classified as youthful offenders.

The commission submits the following list of variations and program alternatives of 24-hour care with the recommendation that the proposed child and youth Task Force consider and advise the Division of Mental Health on establishing a number of these programs as needed as a part of a state-wide program for children and youth.

I. Variations of hospital programs for 24-hour care:

a. Psychiatric hospital inpatient unit: provides psy-

Variations and alternatives
to hospital care
Page 2

chiatric treatment, nursing care, ancillary therapies, special education, and family services on an emergency, intensive or extensive basis.

[25]

b. Night hospital program: psychiatric hospital unit offering overnight bed space, psychiatric and nursing care; patient is involved in community activities (work or school) during the day.
c. Guest program: psychiatric hospital unit providing a one or two day respite for crisis or emergency; patients are not admitted for treatment.
d. Weekend home policy: psychiatric hospital unit which is closed on weekends or which arranges for its five-day week patients to go home for weekends.
e. "Weekend Only" program: patients who are cared for at home during the week are accepted on weekends on the psychiatric unit; such programs enable patients to have access to psychiatric and nursing care when it otherwise would be unavailable with limited bed space; such programs also reduce costs by involving families in partial 24-hour care.
f. Private psychiatric hospital: under this arrangement, the State would purchase services for emergency or intensive treatment for children and youth at private facilities when families are not able to purchase such services privately, and the needed services are not available at public facilities.
g. Specialized residential hospital (with weekend home and rotating bed programs): for children and youth needing long-term care, alternative care in a specialized residential program offers assistance in self-help skills and in maintaining maturational progress to the extent possible; ordi-

narily children and youth needing such specialized care have limited capacity for returning to normal functioning and will be acclimated toward institutional behavior because of the long-term care needs.

[26]

h. Rotating bed program: more than one patient uses a bed on a rotating basis; particularly effective in interspersing long-term hospital care with periods at home.

II. Variations of 24-hour care not requiring a hospital:

a. Small group crisis home: up to eight children served in a home for temporary or intensive care; psychiatric and nursing services available; admission to crisis homes is on a short-term basis and patient turnover is fairly rapid (eight weeks or under).

b. Small group home: up to eight children requiring a different living situation but not in need of having a specialized treatment environment; psychiatric and nursing care services available on a consultative (or on-call) basis.

c. Specialized small group living home: designed for children needing long-term care of a specialized nature; this varies from the specialized psychiatric hospital in that the program is conducted in a small group home with not more than six children.

d. Small group home clustering: by clustering a number of small group homes in close proximity, it is possible to provide more effective psychiatric and nursing care to a greater number of children; such closeness provides for easy patient movement from home to home; i.e., from a crisis home to a small group, non-crisis home.

e. Therapeutic camp life: generally used for intensive or extended treatment; allows children to participate in a therapeutic environment in a primitive but wholesome setting; psychiatric services available.

[27]

f. Specialized foster parent program: foster families selected to provide specialized foster care to disturbed children; such parents would be assisted through on-going instruction from mental health workers in therapeutic management of their disturbed foster children; a variation of this program would be specialized foster parents for weekends only, thereby providing a hospitalized child without a family a weekend home program.

g. Rotating parent program: parents of children in treatment share in the care of each other's children on daily, weekend, or weekly basis; such a program often provides intermittent relief for parents without having to hospitalize the child. The State should compensate the participating parent on an hourly basis.

h. Home care services: mental health treatment team (based in community or hospital) visits the child's home on a weekly basis, or more frequently if needed, in order to assist the parents in home management; in this way parents are taught treatment procedures and effective management while the child lives at home.

i. Private child care agencies: an arrangement whereby the State purchases care at numerous private child care agencies on a temporary, intensive, or extensive basis at private facilities providing 24-hour child care and treatment ser-

Variations and alternatives
to hospital care
Page 5

vices, when families are not able to purchase services privately and the needed services are not available at public facilities.

III. Outpatient and day treatment program alternatives:

a. Child and youth services at a community mental health center: a component of a community treatment center with staff trained and experienced in children and youth services; major emphasis on supportive services to families and schools.

* * * * *

[51]

Admissions/Policies

RECOMMENDATION: 9

ADMISSION GUIDELINES FOR CHILDREN AND YOUTH TO STATE HOSPITALS NEED TO BE MORE SPECIFIC.

The commission supports the general policy tone indicated in revised Policy Memorandum No. 20-01, dated May 10, 1973.* This policy memorandum makes note that admission policies for "mentally retarded or other developmentally disabled persons"** are currently being developed. However, no reference is made to the need to develop admission policies specific to children and youth.

The commission interprets this policy as stressing the

*See Appendix, p. D-1.

**Currently "developmentally disabled" includes individuals with cerebral palsy, mental retardation and epilepsy, but not emotional disturbance or mental illness.

Admissions/Policies

responsibility of each hospital for obtaining appropriate alternative service when indicated. It should be noted that such a policy is presently difficult to implement because there are so few of the needed alternative services for children and youth.

In particular, the commission stresses the need to protect children and youth from being inappropriately [52] admitted to state hospitals, and guidelines are needed for assisting admissions staff in determining appropriate alternative services.

Careful diagnostic studies should be performed prior to admission in all but acute emergencies, and appropriate service needs should be determined on the basis of such studies.

Children and youth staff should be assigned to admissions with responsibility to see that child and family get to the most appropriate source of service, i.e., implementing the criteria established for admission of children and youth units or alternative services. A temporary, "crisis assistance" person should be available from the child and youth units.

Staff training should be conducted by the Developmental Services Section of the Mental Health Division at each hospital regarding interpretation of Policy No. 20-01 and subsequently developed policy guidelines for admission of children and youth. Such training should include all hospital staff with work assignment in admissions including the hospital's clinical director and all staff involved in admissions from the children and youth units.

* * * * *

[A-4]

* * * * *

ADMINISTRATION

The concept of regionalization for children and youth is an improvement over having one central facility in the state. The overall hospital support for the child and youth programs is high. Administrative staff apparently place great emphasis on these services. This support is essential to the development of a high quality program. However, under the present staffing patterns and lack of space for children and youth at the regional hospitals, outpatient and day care services cannot be and therefore have not been developed adequately.

There are certain factors at work which are significantly impeding the current policies of the regional hospital system for improving child and youth services and reducing inpatient length of stay:

(a) type of building: child and youth units generally were designed for long-term treatment. Except for GMHI, none have outpatient or day program space.

The children's buildings are new, well-equipped, and well-maintained. Such a physical plant contributes greatly to a therapeutic environment, but their potential for specialized use for children's programs is greater than their present uses.

Facilities and programs for adolescents are far behind programs for children. There are no separate physical facilities for youth except at GMHI and CSH. At CSH the youth building is such an incredibly [A-5] poor facility as to bring question to its effectiveness in rehabilitation. This building is decrepit and does not provide the privacy and facilities which are a primary element of a therapeutic environment.

Except for GMHI, none of the hospitals have adequate space for adolescents. Each insitution has solved its problem differently and ingeniously considering the limitation. Various arrangements include housing adolescents in children's unit with children (thereby reducing to half the number of available beds for each age group and by half again if sex segregation is maintained). At one hospital, the physical facility for adolescents is so poor that very little treatment can be done (only behavior control for adjusting to institutional expectations). In addition to approximately 85 adolescents housed in the adolescent unit, there are approximately 85 more housed on geographic units with adults.

(b) treatment programs: the programs generally are institutional in character and extremely limited in opportunities for normal childhood experiences.

(c) type of children served at regional hospitals: at three of the five regional hospitals the staff reports that a majority of the children need not be hospitalized if alternative services were available in the community. At the other two hospitals the staff reported that the length of stay could be significantly reduced if there were adequate follow-up services.

Between 50-75% of children served in these institutions have no family or are part of severely dysfunctional famility units (e.g., DFCS custody).

[A-6]

More than 50% of children served are characteristically aggressive, anti-social, hyperkinetic or runaways, and non-psychotic. The child and youth population of the regional hospitals in many respects is similar to those identified as youthful offenders, except they have not been sentenced.

* * * * *

[A-8]

* * * * *

ADMISSIONS

1. Admissions decisions at all but two hospitals are primarily the responsibility of the hospital's central admissions office. Unit staff do not participate in admissions decisions, generally.

[A-9]

2. The hospitals' ability to assure that all the children and youth who are admitted are, in fact, in need of hospital care is seriously limited by the present lack of community alternatives able to provide help to emotionally or behaviorally-disordered children and youth.

3. At present, the units have what is essentially an open admissions policy for children. Since this is in effect an involuntary procedure for the children themselves, there is a major responsibility to at least investigate the appropriateness of alternative resources in the community before accepting them into the hospital. Most units' ability to do this is limited by a lack of alternative community programs, and the children and youth personnel identified this as one of the major problems.

4. The policy at one hospital requiring that all young girls who are pregnant or known mothers be placed on adult geographic units raises questions about the placement procedures for girls between the ages of 12 and 16 years.

* * * * *

[A-14]

* * * * *

DISCHARGE AND COMMUNITY FOLLOW-UP SERVICES

1. Generally, discharge decisions are collectively made at staffings but are not now tied to previously written treatment objectives for each child.

2. At present, discharge is hampered by the lack of intact families to return children to. Few parents are able to take advantage of the services provided at the hospitals themselves and apparently little field work with parents is done. In one instance, the present amount of social work service assigned seriously limits the amount of parent services, field services, and community agency liaison services offered.

3. Community liaison and resources for pre-referral evaluation and post-discharge placement are limited.

4. Some patients stay years because there is no place for them to go and there are only limited comprehensive community services available.

5. Field services with geographically distant communities are not systematically provided.

* * * * *

[1]

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

AFFIDAVIT

Personally appeared before me the undersigned officer duly authorized to administer oaths, ROMAE T. POWELL, who states on oath as follows:

1.

I am Romae T. Powell, and I am and have been one of the Juvenile Court judges for the Juvenile Court of Fulton County. I have been in that position for 3 years. In addition, I am a member of the Executive Committee of the Council of Juvenile Court Judges of Georgia, established by Ga. Code § 24A-501. In my capacity as a Judge of the Juvenile Court of Fulton County and as a member of the Executive Committee of the Council of Juvenile Court Judges, I have personal knowledge of the matters set forth in this affidavit and the requisite experience and knowledge to support my opinions which are stated herein. I make this affidavit for use by the defendants in the above-styled action, particularly in support of their application to stay the order of this Court and any judgment thereon pending disposition of the defendants' appeal and offer this in lieu of my testimony since, because of my court's caseload, its demands on my time, and the time limitations provided by the Juvenile Court Code in which to hold hearings (24A-1701(a)), I cannot lose the time which would be required by a personal appearance before the Court.

ATTACHMENT TO
EXHIBIT C

[2]

[2]

2.

I have examined the order of the federal court entered in the above-styled matter on February 26, 1976. For a number of reasons, including those which are set forth in detail below, that order will cause and impose a further burden on what is already an overworked, overburdened juvenile court system and will serve to impede the fair, speedy and equitable administration of justice in juvenile matters.

3.

Initially, there are presently two juvenile court judges who sit in Fulton County. Presently, each of the two judges disposes of approximately ten (10) cases per day, and the juvenile court's four referees dispose of an additional twenty (20) to thirty (30) such cases. The case load which we presently have obviously taxes, almost to our limit, our ability to dispose of cases promptly and in an equitable fashion. Any order or ruling which will increase the caseload of our court will obviously impact on our ability to handle our current caseload.

4.

In addition to the burden imposed by the increase in the caseload, the character of the matters which will be brought before us as a result of the federal court's order will in and of itself have a greater impact on our ability to administer speedy resolutions to our juvenile cases than would a case where the child was alleged only to be delinquent or unruly.

5.

I say this because it is my understanding that most admissions to mental health facilities which are sought by

parents, generally occur when the child is in need of immediate hospitalization, which necessitates taking the child into custody prior to an opportunity for a hearing. Under the Juvenile Court Code, whenever a child [3] is taken into custody without a petition having been filed and an order of the court issued, the child is entitled to an informal detention hearing within seventy-two (72) hours of being taken into custody.

6.

Additionally, the law provides that whenever a child is in custody, the child is entitled to a full adjudicatory hearing within ten (10) days after having been taken into custody. The court has little leeway in this matter and thus, it would be necessary that we adjust our calendars and schedules to accommodate those cases which involve children who have been detained in the mental hospitals, to the detriment of those other pending cases which will have to be delayed while we hear these cases.

7.

Further, the cost of holding these hearings has not been budgeted and is not included in the court's appropriation. The Juvenile Code, as well as the federal court's order, contemplates a proceeding which will be conducted in the nature of an adversarial hearing, with the parents on one side and the child on the other. Under the Code, this will necessitate the appointing of a guardian ad litem in each instance. For private attorneys in this county, we pay a maximum of $250.00 for each juvenile court hearing. Of course, the Code also requires that every hearing be recorded, unless waived, which adds additional costs.

8.

There are other costs which cannot be directly calcu-

lated for the adjudicatory hearing in the juvenile court requires the presentation of evidence on the matters asserted. That is, if it is alleged that the child is mentally ill and in need of hospitalization, evidence to that end will have to be presented to the [4] court. This will require the appearance in court of the mental health personnel who have the expertise to advise and assist the court in reaching a proper disposition of the case. Obviously, if the personnel of the mental health facilities are required to appear in court, the time during which they will be able to direct their talents to more beneficial purposes, will be diminished.

9.

There are additional immediate problems with respect to the federal court's order. In the past, it has brought to the juvenile court's attention that certain children might be mentally ill, and the court has processed the children through the regional hospitals for evaluation. However, there have been few, if any, cases filed in which the petition was based solely on an allegation that the child was mentally ill. In fact, it has been my experience that when it has appeared to the court that the child was mentally ill, the court has often directed the child's parents to simply take the child to a proper facility and to have the child admitted for treatment. The court has not sought to create an adversarial situation when a child is in need of mental health treatment and this has been avoided by simply directing the parent to take the child to a facility where proper treatment can be had.

10.

It is also my opinion that the juvenile court system is not equipped to deal with cases where the only allegation made in a petition is that the child is mentally ill.

Our court personnel are trained to handle delinquent and unruly children, but do not have any special training which would allow them to deal with children who are not normal in their responses to directions, rules and instructions necessary in running a detentional [5] facility. Further, this Court's facilities will not allow us to efficiently segregate the mentally ill children from the other children detained by the court, with the resulting possibility of harm to both groups of children. Finally, the court may be further burdened in that the courts personnel, pursuant to Ga. Code § 24A-2101, may be required in some cases, to make independent investigations into the allegations set forth to the court, and the court does not have sufficient personnel to even do this. Hence, I cannot even conclude that Fulton County at present has the facilities and the personnel to properly care for children who are brought to us by their parents seeking treatment for their mentally ill children.

11.

While the impact of the decision on my court is significant, the decision will cause even more difficulties in less urban counties. While the metropolitan counties have a fairly well-developed juvenile court system, the same is not necessarily true in the other counties throughout the State. In most of the counties the superior court judge acts as judge of the juvenile court. This is important because some superior court judges are required to sit in the various counties in their circuit, which means that they may or may not be in the county in which they are the juvenile court judge when a child needs hospitalization. Let me demonstrate this problem by using the Oconee Judicial Circuit which consists of six counties, Bleckley, Dodge, Montgomery, Pulaski, Telfair and

Wheeler and which has only one judge. Under the Juvenile Code as it is presently written, a juvenile must be brought before the juvenile court which is located in the county of his residence. Liberally interpreting this, it means that he must be brought at the minimum before the judge of the juvenile court of his county. However, if the judge for the Oconee Judicial Circuit is holding court in [6] Hawkinsville, the county seat of Pulaski County, and a child who is located in Wheeler County needs medical treatment, it would be necessary, if the child is taken into custody, to transport the child as much as 50 or 60 miles one way to the superior court judge, unless the child's appearance is waived. Further, as the federal court should well know, the superior court judges sit in the counties for various periods of time depending on their calendar. Because of the ten-day limitation contained in the Juvenile Code, it may be necessary to transport that same child from Wheeler County or wherever he is detained together with all of the witnesses and other evidence pertaining to his mental illness to Hawkinsville a second time in order to have a required formal adjudicatory hearing. Alternatively, it may be necessary to move the court, including the judge, the attorneys, the court reporter and the other court personnel to the child, which would be equally burdensome. In short, in counties which are not as fortunate as Fulton County, it may be necesary to transport both the children, who of course are alleged to be mentally ill, as well as the mental health personnel and other witnesses and evidence great distances in order to get the hearing which the federal court's order and the Juvenile Code will require, all of which could only be to the detriment of the mentally ill child who is in need of treatment.

12.

I wish the federal court to know that I do agree that we need some procedure to protect the children in mental health facilities from being abandoned by their parents, but I perceive that the Juvenile Code, if properly used, provides this safeguard since petitions alleging abandonment or other deprivation can be filed by any person at any time. To require, instead, that every child be brought before a juvenile court has ramifications which are far more serious than may appear at first. Adversarial [7] hearings in the juvenile courts are often emotionally traumatic. Placing a parent and a child in an adversarial situation when in fact they do not wish to be adversaries, and when in fact the parent is only seeking the best for his child, would, in my opinion, harm the family relationship. As I noted, I will be required to appoint guardians ad litem for each child alleged to be mentally ill, and it will presumably be that it will be counsel's job to insure that the parents are not acting adversely to the child's best interest. This will require the child's parents to prove, in court, that the child is in fact mentally ill. It is my opinion that when faced with this choice, there are going to be a great number of parents who simply choose not to seek the proper treatment for their children. As a result, the children are going to suffer, and by the time the problem is discovered because the child commits an act of delinquency, or takes some other action which brings him to the juvenile court's attention, the harm will be done. Any action which discourages a parent from seeking the proper care for his child should be avoided.

13.

Finally, I would note that it is my opinion that the court's opinion is going to most adversely affect poor

people. When faced with the prospect of going to the juvenile court and having an adjudicatory hearing in which their child is to be declared mentally ill, those persons who have the means to do so will undoubtedly simply resort to private mental health facilities. Unfortunately this answer is not available to persons who are poor. They have no place to go other than the state supported hospitals, and as a result, it is the children of the poor people who will be deprived of the proper care and treatment. Any other or decision which will have an adverse impact on an economically disadvantaged group should be avoided.

[8]

14.

Therefore, in sum, it is my opinion that the requirements of the judicial intervention be sought every time a parent or guardian seeks to place a child in a mental health care facility will:

(1) Add to the already overburdened dockets of the court system; and

(2) Create many extreme problems with respect to the swift, speedy and fair administration of justice of the juvenile court system; and

(3) Create an unreasonably emotionally traumatic situation, particularly in those cases where a parent is genuinely concerned with the child's welfare and is only trying to seek the best assistance possible for the child; and

(4) Cause many parents to refrain from taking the necessary action to obtain mental health care and treatment needed by the children; and

(5) Have a disproportionate effect on economically disadvantaged persons throughout the State.

/s/ ROMAE T. POWELL
ROMAE T. POWELL
Judge

Sworn to and subscribed
before me this 8th
day of March, 1976.

/s/ ANNE S. DAVIS
Notary Public

Notary Public, Georgia, State at Large
My Commission Expires July 29, 1978

[1]

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

AFFIDAVIT

Personally appeared before me the undersigned officer, a person duly authorized to administer oaths, Dennis F. Jones, who states on oath as follows:

1.

I am Dennis F. Jones and I am and have been one of the Juvenile Court Judges for the Juvenile Court of De Kalb County. I have been in that position for 3½ years. In addition, I am the president of the Council of Juvenile Court Judges, of Georgia established by Ga. Code § 24A-501. In my capacity as a Juvenile Court Judge and as president of the Council of Juvenile Court Judges, I have personal knowledge of the matters set forth in this affidavit, and the requisite experience and knowledge to support my opinions which are stated herein. I make this affidavit for use by the defendants in the above-styled action, particularly in support of the application to stay the order of this Court and any judgment thereon pending disposition of the defendants' appeal.

2.

I have examined the order of the federal court entered in the above-styled matter on February 26, 1976. For a number of reasons, including those which are set forth in

detail below, that order will cause and impose a further burden on what is [2] already an overworked, overburdened juvenile court system and will serve to impede the fair, speedy and equitable administration of justice in the juvenile matters.

3.

Initially, there are presently two juvenile court judges who sit in DeKalb County. At the present time, because of the caseload involved in serious matters such as delinquency petitions as well as those situations where a child is truly deprived of parental assistance and guidance, we are able to only hear approximately thirty-five percent of the cases which are filed in our court.

4.

The federal court's order is going to add to this caseload and therefore diminish the juvenile courts' ability to address those cases where a child is actually in need of the court's services.

5.

Further, this problem of the increased caseload will be compounded in that it is apparent that most admissions to the mental health facilities which are sought by parents will be in the nature of an emergency and it will not be feasible to file a petition in the juvenile court prior to taking the child into detention, and this will necessitate at least two hearings for each child sought to be hospitalized by his parents.

6.

This will occur because the law provides that whenever a child is taken into custody and placed in an emergency

detention facility, an informal hearing must be held by the juvenile court within 72 hours.

[3]

7.

After the child has been taken into detention, the law requires that a full, formal adjudicatory hearing take place within ten days. This is important, because it impacts most heavily on the administration of the juvenile court system. Presently, our calendars can be arranged, that is, a delinquent child who is brought before the court can in most instances be released from detention into the custody of his parents or some other responsible adult, thus obviating a necessity of the full adjudicatory hearing within ten days. This allows us to arrange our calendars with some semblance of order. However, with those children who are picked up and placed in the mental hospitals, it would be mandatory that a hearing be held within the ten days following the taking of the child into custody. The court is allowed little leeway in this matter and thus, it would be necessary that we adjust our calendars and schedules to accommodate hearings of these children who have been placed in the mental hospitals.

8.

Additionally, there is the cost of engaging in these types of hearings which has not been budgeted and is not included in the court's appropriation. As I perceive the requirements of the Juvenile Code, and the federal court's order, in every instance where the parents seek to have the child placed in a mental health facility, the court would have to treat the proceeding as an adversarial hearing, with the parents on one side and the child on the other. This will necessitate the appointing of a guardian ad litem in each instance. For private attorneys in

this county, we pay a maximum of $150 for each juvenile court hearing. Of course, the juvenile court law requires that every hearing be [4] recorded, unless waived, which adds additional cost and we require that other court personnel also be involved in these hearings.

9.

Further, the adjudicatory hearing in the juvenile court requires the presentation of evidence on the matters asserted. This will necessitate the appearance in court of the mental health personnel who have the expertise to advise a court in the proper disposition of a case. Obviously, if the personnel of the mental health facility are spending time appearing in court, the time during which they may direct their efforts in more beneficial matters such as caring for the children is diminished.

10.

The federal court's order raises additional problems. In the past, it has been brought to the juvenile court's attention that certain children might be mentally ill, and the court has processed children through the regional hospitals for evaluation. However, in my memory, there have been extremely few actions filed solely on the basis of the child's mental illness. I raise this issue because the court does not have the proper facilities in which to detain these children. The other children which have been brought before the court have been alleged to be delinquent or deprived or unruly and thus have been maintained in the regular court facilities. However, under the federal court's order, the children involved will be children whose parents or guardians feel are mentally ill. At present I do not have the proper facilities, and particularly the personnel who would be trained to handle mentally ill children. That is, our personnel have been trained in handling delinquent and unruly children but do not have any special training which would allow them to deal with children who are not normal in their responses to directions, rules and [5] instructions necessary in running a detentional facility. Hence, I cannot conclude that these children can be properly cared for in our court at the present time.

11.

While the impact of the decision on my court is significant, the decision will cause even more difficulties in the less urban counties. While the metropolitan counties have a fairly well developed juvenile court system, the same is not necessarily true of the other counties throughout the State. In fact, there are only approximately thirty-five counties which have regularly appointed juvenile court judges. In the remaining 124 counties, the superior court judge sits as juvenile court judge and must handle the juvenile court cases in addition to all his other duties. The impact of this is, of course, obvious. While the juvenile courts in the metropolitan counties were specifically established for juveniles, the superior courts throughout the State are not. If the DeKalb County Juvenile Court does not have the proper facilities and the wherewithal to handle children whose only offense is that they are allegedly mentally ill, it is obvious that in other counties in which the superior court must act as the juvenile court, there will not be even the inadequate facilities which exist in DeKalb County.

12.

It is important to note that I do not object to the concept of preventing situations where children are "dumped" in mental hospitals. However, it seems obvious, to use a

well worn phrase, that the cure here might be worse than the illness. It is my opinion, as I have previously stated, that the proceedings re-[6]quired by the federal court order to take place in my court, will have to be maintained as an adversarial proceeding, in that I will have to appoint counsel for each of these children and presumably, it would be the counsel's task to insure that the parents are not acting contrary to the best interests of the child. It has been my experience that the proceedings in the juvenile court system are often emotionally traumatic when the persons are placed in adversarial positions. Placing a parent and a child in an adversarial situation when in fact they do not wish to be adversaries, and when in fact the parent is only seeking best for his child, would, in my opinion, harm the family relationship. While recognizing that a problem may exist in this area, it is my opinion that there is no need to force a parent and child into an adversarial situation in which they do not wish to be, a situation which might well result in the worsening of the child's condition, or cause the parent to refrain from seeking the help the child needs. While it is agreed that a very few children might be "dumped" by their parents, there are other methods that can provide judicial protection against abandonment of children through long term commitments which would not necessarily cause the emotional trauma or the imposition on the family relationship as will the adjudicatory hearing which is being required by this court's order.

13.

Therefore, in sum, it is my opinion that the requirements that judicial intervention be sought every time a parent or guardian seeks to place a child in a mental health care facility will:

[7]

(1) Add to the already overburdened dockets of the juvenile court system;

(2) Create many extreme problems with respect to the swift, speedy and fair administration of justice of the juvenile court system; and

(3) Impose an emotionally traumatic situation, particularly in those cases where the parent is genuinely concerned with the child's welfare and is only trying to seek the best assistance possible for the child.

(4) Cause many parents to refrain from taking the necessary action to obtain mental health care and treatment needed by their children.

(5) Cause the psychiatrists, psychologists, and other mental health people to spend much of their valuable time in courts rather than in treating the children.

/s/ DENNIS F. JONES
DENNIS F. JONES
Judge
Juvenile Court of DeKalb County

Sworn to and subscribed
before me this 4th
day of March, 1976.

/s/ R. DOUGLAS LACKEY
Notary Public

Nov. 3, 1978

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(TITLE OMITTED IN PRINTING)

OPINION OF THE DISTRICT COURT

(Opinion of the district court constitutes Appendix "A" to the Appellants' Jurisdictional Statement)

[1]

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

(Caption omitted in printing)

[Filed at 1:00 P.M. Mar. 11, 1976, Walter F. Doyle, Clerk, U.S. District Court]

JUDGMENT PURSUANT TO RULE 54(b), FEDERAL RULES OF CIVIL PROCEDURE

A district court of three judges having rendered its decision on February 26, 1976, as to all matters required to be decided and heard by a court of three judges and having dissolved itself, this constitutes an express determination by the court that there is no just reason for delay of entry of judgment as to all matters required to be heard by a district court of three judges and an express direction for the entry of said judgment. Rule 54(b), Federal Rules of Civil Procedure.

In the manner set forth in the remedial portion of said February 26, 1976, decision which begins on page 42 and continues through page 45, judgment is therefore rendered for the plaintiffs [2] individually and as representatives of the plaintiff class and against the defendants: JAMES PARHAM, individually and as Commissioner of the Department of Human Resources, DOUGLAS SKELTON, individually and as Director of the Division of Mental Health, and W. T. SMITH, individually and as Chief Medical Officer of Central State Hospital.

Judgment pursuant to Rule 54, Federal Rules of Civil Procedure, is expressly not entered as to those portions of said February 26, 1976, order (a) by which a single district judge court continues to have jurisdiction of every child who is a member of the plaintiff class for the pur-

poses stated on pages 43 and 44, and (b) directing the parties to appear on April 21, 1976, before a single district judge to then report in full on all efforts made to effect this order at which time further orders needed to clarify or make explicit said remedial order may be passed by a single district judge.

This 11th day of March, 1976.

/s/ WALTER F. DOYLE
WALTER F. DOYLE, Clerk
United States District Court

Entry directed by and
form approved by

/s/ WILBUR D. OWENS, JR.
WILBUR D. OWENS, JR.
United States District Judge

[1]

IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF GEORGIA MACON DIVISION

(Caption omitted in printing)

[Filed at 4:00 P.M. Mar. 17, 1976, Walter F. Doyle, Clerk, U.S. District Court]

Defendants Parham, Skelton and Smith, individually and as officials of the Department of Human Resources of the State of Georgia, have moved this district court of three judges[1] to stay its entire order of February 26, 1976, and the judgment entered March 11, 1976, pending their appeal to the Supreme Court of the United States. For grounds they urge:

> "1. A stay is necessary in order to maintain the status quo and to prevent the issues from becoming moot during the appeal.

[2]

> "2. A stay is necessary in order to protect the public interest during the appeal of the court's order.
>
> "3. A stay is necessary in order to prevent irreparable injury to the members of the plaintiff class during the appeal of the court's decision."

Defendants' motion filed on March 10, 1976, was heard on March 11, 1976. Evidence presented and arguments read and heard having been considered, this constitutes the court's order on defendants' motion.

[1] This court as originally constituted consisted of Circuit Judge Bell, Senior District Judge Bootle and District Judge Owens. Following the court's decision of February 26, 1976, Circuit Judge Bell's resignation became effective on March 1, 1976. Upon notification of the intention of the defendants to [2] file its motion the court was reconstituted by Chief Judge Brown to consist of Circuit Judge Morgan, Senior District Judge Bootle and District Judge Owens.

The defendants by brief and in argument suggest that they satisfy the four criteria which traditionally are considered by trial courts in deciding whether or not to grant a stay pending appeal, to wit: "(1) the applicant must establish a strong likelihood of success on the merits; (2) the applicant must show that he will be irreparably harmed if the stay is not granted; (3) the applicant must show that the other party will not be irreparably harmed by a stay; and (4) the applicant must show that the public interest will be served by the stay." Defendants' brief in support of motion.

The defendants first concede the obvious—this district court of three judges would not have unanimously decided that children cannot be voluntarily committed and detained in Georgia's mental hospitals pursuant to this statute which contains absolutely no due process protection, if it were of the opinion that on appeal the defendants are likely to convince a majority of the Supreme Court to hold to the contrary. Having so conceded, defendants suggest that nevertheless this is a new, novel issue similar to Kremens v. Bartley, 402 F.Supp. 1039 (E.D. Pa. 1975), which was stayed by the Supreme Court on December 15, 1975, and that said stay is a signal that they may indeed prevail upon appeal.

The court secured a copy of the motion for a stay in Kremens as considered and granted by the Supreme Court and again read the decision that was being appealed. Kremens it is first noted, con-[3]siders whether or not a statutory procedure and regulations pertaining thereto which collectively contain some due process type protection for children, described in the dissent of Judge Broderick as follows:

"Under the Pennsylvania Act and regulations, ap-

plication for voluntary admission or commitment to a facility may be made by a parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years or younger. In order to be admitted or committed to an institution, any person aged 18 and younger must first be referred from a recognized medical facility, Mental Health/Mental Retardation therapist or Mental Health Agency. Such referral must be accomplished by a psychiatric evaluation and a report which states with specificity the reasons that the child requires institutional care. After such referral, the director of the facility to which the parents seek to have their child admitted must then conduct an independent examination of the child in order to determine whether the child is in need of institutional care or observation. If the director's independent examination disagrees with the referring professional's opinion, the child cannot be institutionalized. In the case of a voluntary commitment under §403 of the Act, an acceptance for commitment may not exceed thirty days without a successive application for continued voluntary commitment for an additional thirty day period. In the case of juveniles 13 years of age and older, within 24 hours of admission to the institution, the juvenile must be given written notification which he signs and which is to be fully explained to him and which states that he will be furnished with counsel to represent him. Should a juvenile who is 13 years of age or older object, either orally or in writing, to remaining in the institution, the director, if he feels it is necessary for the youth to remain, may continue the institutionalization for two business days, during which time notification shall be made to the applicant and the referral unit so that either party may institute a §406 proceeding, which is the statutorily required court hearing for an involuntary commitment. During that same two day period, the director must obtain counsel to represent the juvenile. The juvenile's counsel is then

furnished with the evaluation of the juvenile by the referral unit, a psychiatric evaluation from the institution, and a written report of the reasons that the institution feels that institutionalization is required.

"The effect of the Act and the regulations promulgated thereunder is that two independent medical opinions must concur in a recommendation of institutionalization before a minor can be voluntarily admitted. In the case of juveniles 13 and over, upon their objections to remaining in the institution, future institutionalization must proceed pursuant to the civil court commitment provisions of the Act. (Section 406). Section 406 provides the procedure for an involuntary civil court commitment and requires the filing of a petition with the Court of Common Pleas, pursuant to which the Court issues a [4] warrant requiring the allegedly ill person to be brought to Court for a hearing. Counsel appointed for the juvenile represents him at the hearing before the Court of Common Pleas. After the hearing, the Court may order an examination by two physicians or order commitment for a period not to exceed ten days for an examination, after which commitment may be ordered by the Court. Plaintiffs do not attack the constitutionality of the civil court commitments under §406 of the Act which follow the above outlined procedure." (footnotes omitted). Kremens, supra, dissent of Judge Broderick, pp. 2-5.

meets due process requirements. The Kremens court decided that these protections are constitutionally inadequate and went further to decide in minute detail what protections are required. Having spelled out every detail the court as to thousands of children in both mental health and mental retardation facilities in Pennsylvania gave the defendants 120 days to initiate and complete recommitment or discharge procedures. Unlike Kremens the decision of this court is only that some due process

protection is required for children to be voluntarily committed to a mental hospital. Unlike Kremens this court's order requires that as to only those 154 children (Dr. Skelton's affidavit in support of motion) who were in defendants' custody on January 31, 1976, proceedings be just commenced—not commenced and completed—in one of Georgia's 159 juvenile courts or one of Georgia's 159 courts of Ordinary within 60 days from the court's order of February 26, 1976. In chambers on January 8, 1976, the defendants were advised that the court's order would allow this 60 day period so in reality they have had an additional 48 days within which to commence such proceedings. Since Georgia's juvenile court system in fiscal year 1974 disposed of 48,116[2] juvenile cases, 154 additional cases scattered throughout this entire state and commenced over a sixty day period should not create an extraordinary problem for the fine juvenile court system that we have in this state. That Kremens and its particular facts demonstrated a crying need for a stay, does not in any way indicate a similar crying need in this case the facts of which are totally different.

[5]

To demonstrate irreparable harm to the defendants they assert that while they as state officials will not be harmed, the people who are served by the State's mental health program will be harmed by the monetary cuts that will have to be made in some services to fund the creation and operation of non-hospital facilities ordered by the court. As the Supreme Court of Georgia reminded all state officials on December 4, 1975, in the case of Busbee v. Georgia Conference, American Association of Univer-

[2] Second Annual Report, Administrative Office of the Courts of Georgia.

sity Professors, 235 Ga. 752, ___ S.E.2d ___ (1975), even the failure of the legislature of this state to appropriate money for a particular purpose does not lessen the legal obligation of state officials to perform their lawful duties using money available for other purposes.

While the defendants did confer with the governor and legislative leaders in January 1976 in response to the court's request that they do so and while Dr. Skelton's affidavit shows that they then said funds were unavailable because they among other things, were of the "opinion that the regional hospitals were offering appropriate treatment for children" (February 26 Order at 18), it now appears that the defendants between February 26, 1976, and the adoption of a final budget about a week later did not request the legislature or the governor to appropriate money to cure and correct the admitted in appropriate treatment of a large number of plaintiff children. Defendants say to even make such a request would be a futile effort. Until such time as each representative and senator and the governor of this state—all fathers and grandfathers like the judges of this court—have been told of the facts of this case and presented with a formal request for such funds and until such time as they have formally denied such funds, this court will not accept defendants' contention that it would be futile to make such a request. Having elected to refrain from communicating with the legislature, defendant state officials can decide[3] for themselves how to go about shifting funds to comply with the court's order.

[3] The defendants are reminded that the Supreme Court declined to hear the plea they are now making in Department of Human Resources v. Burnham, 43 U.S.L.W. [6] 3683 (U.S. June 30, 1975) (No. 74-904), *denying cert. to* 503 F.2d 1319 (5th Cir.). In that case, one of the questions presented in the petition for certiorari was:

> "Can federal district court, consistent with Eleventh Amendment, entertain suit by private individuals that would require state to re-order its priorities and increase its level of fiscal support for therapeutic or curative psychiatric treatment it provides in its mental institutions?"

43 U.S.L.W. 3459 (U.S. Feb. 18, 1975) (No. 75-904).

[6]

While they steadfastly refuse to so admit, their failure to request funds could be due to their agreement with this court's opinion that the creation and operation of appropriate non-hospital facilities for these children in reality will save rather than cost money, i.e. hospital care costs some $40,000 per year per child whereas group home care costs some $7,500 per year per child; residential treatment care centers cost $12,000 per year per child.

As the evidence shows, the defendants agree that less stringent, non-hospital facilities are needed and are more appropriate but they want to provide them when they deem it advisable to do so, not when this court orders them to do so. To be compelled to do what admittedly should be done is not to be harmed.

Defendants say that plaintiff minor children are being harmed by the court's present order because that order is setting priorities for the Department of Human Resources. "As an alternative to allowing the court to set priorities for the Department, the Department can and will simply relinquish custody of the 46 children to the persons who placed the children with the Department." They would thus be deprived of their present care and treatment. A stay would prevent this harm and permit their present care and treatment to continue. Thus they conclude that a stay would help rather than hurt these children.

Implicit in this court's February 26, 1976, order is the court's considered opinion that every minute of unnecessary or inappropriate confinement and detention of a child in a mental hospital is a deprivation of liberty which affects him adversely and from the harmful effects of which he may never recover. That considered judgment has not changed.

[7]

The defendants go on to say that the public interest will be served by a stay because it is in the public interest to encourage and make it easy to admit children to mental hospitals rather than discouraging their admittance by requiring an adversarial juvenile court hearing. They also say it is in the public interest to not burden Georgia's juvenile court system with mentally ill children.

The evidence shows that in spite of requested permission to do so, defendants between January 8 and February 26, 1976, did not apprise their employees that they were expecting an adverse ruling and that it would soon be necessary to either petition juvenile court or assist parents in petitioning juvenile court to admit children in need of treatment. The confusion that defendants say exists, the reported reluctance of some parents to process their children through juvenile court, results from a total lack of effort on defendants part to prepare their employees to communicate with parents and juvenile courts and to implement the order that they had been told was coming. Any parent who sincerely believes that his child is mentally ill and in need of treatment will not hesitate to have his child civilly committed through juvenile court or any other court process. Proof of this is that according to the defendants 1,111 children were involuntarily court committed during the fiscal years 1969 through 1976. Order of February 26, 1976 at 10.

The legislature of this state after careful study enacted an already described completely revised Juvenile Court Code in 1971. That code provided then and provides now for children who are mentally ill. 1933 Ga. Code Ann. § 24A-301 and 2601. That code contains already mentioned due process safeguards. To begin to utilize this revised juvenile court code for mentally ill children will be only to do in 1976 what the legislature of this state provided to be done beginning in 1971. The total of 22 children defendants estimate will be the subject each month of juvenile court proceedings will be a small addition to the said 48,116 juvenile cases handled on a yearly basis in Georgia's juvenile courts.

[8]

The State is being required to utilize an existing court system and to create non-hospital facilities that they themselves say they need and eventually want. Neither the utilization of juvenile courts nor the creation of such needed, wanted facilities will moot the issues upon appeal because if defendants prevail upon appeal, they will be free to return to the statutory system still deemed by this court to be violative of the Due Process Clause of the Fourteenth Amendment to the Constitution of the United States. Alee v. Medrano, 416 U.S. 802, 811, 40 L.Ed 2d 566, 578, 94 S.Ct. 2191, ——, to wit:

> "It is settled that an action for an injunction does not become moot merely because the conduct complained of has terminated, if there is a possibility of recurrence, since otherwise the defendants 'would be free to return to ". . . [their] old ways." ' Gray v. Sanders, 372 US 368, 376, 9 L Ed 2d 821, 83 S Ct 801; Walling v. Helmerich & Payne, Inc. 323 US 37, 43, 89 L Ed 29, 65 S Ct 11; United States v. W. T. Grant Co. 345 US 629, 632, 97 L Ed 1303, 73 S Ct

894; NLRB v. Raytheon Co., 398 US 25, 27, 26 L Ed 2d 21, 90 S Ct 1547; SEC v. Medical Committee for Human Rights, 404 US 403, 406, 30 L Ed 2d 560, 92 S Ct 577. . . ."

Defendants' arguments presented and considered are essentially a restatement of contentions made before the court issued its February 26, 1976, order. Then and now they have been considered and found wanting.

It is therefore the carefully considered judgment of this court that it is in the best interest of the plaintiff minor children that defendants' motion to stay pending appeal is denied.

IT IS SO ORDERED this 17th day of March, 1976.

/s/ LEWIS R. MORGAN
LEWIS R. MORGAN
United States Circuit Judge

/s/ W. A. BOOTLE
W. A. BOOTLE
Senior United States District Judge

/s/ WILBUR D. OWENS, JR.
WILBUR D. OWENS, JR.
United States District Judge

[1] **IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF GEORGIA MACON DIVISION**

(Caption omitted in printing)

NOTICE OF APPEAL
TO THE SUPREME COURT
OF THE UNITED STATES

Notice is hereby given that T.M. "Jim" Parham, Douglas Skelton, M.D. and W.T. Smith, defendants above named, individually and in their official capacities, hereby appeal to the Supreme Court of the United States, from the order of this Court entered in this action on the 26th day of February, 1976, and the final judgment entered thereon on the 11th day of March, 1976.

This appeal is taken pursuant to 28 U.S.C. § 1253.

This 24th day of March, 1976.

ARTHUR K. BOLTON
Attorney General

ROBERT S. STUBBS, II
Chief Deputy Attorney General

/s/ DON A. LANGHAM
DON A. LANGHAM
Deputy Attorney General

/s/ TIMOTHY J. SWEENEY
TIMOTHY J. SWEENEY
Senior Assistant Attorney General

/s/ R. DOUGLAS LACKEY
R. DOUGLAS LACKEY
Assistant Attorney General

Please Serve:

Timothy J. Sweeney
132 State Judicial Building
Atlanta, Georgia 30334
Phone: 656-3340

SUPREME COURT OF THE UNITED STATES

[Filed at 9:30 A.M., Jun. 6, 1977, G. W. Hawkins, Deputy Clerk, U.S. District Court, MIDDLE DISTRICT OF GEORGIA]

No. 75-1690

JAMES PARHAM, individually and as Commissioner of Department of Human Resources, et al.,

Appellants,

v.

J. L. and J. R., minors, etc.

APPEAL from the United States District Court for the Middle District of Georgia.

The statement of jurisdiction in this case having been submitted and considered by the Court, probable jurisdiction is noted. In addition to the questions presented by the jurisdictional statement the parties are directed to brief and argue the following question:

> "Whether, where the parents of a minor voluntarily place the minor in a state institution, there is sufficient 'state action,' including subsequent action by the state institution, to implicate the Due Process Clause of the Fourteenth Amendment?"

May 31, 1977

A true copy MICHAEL RODAK, JR.
Test:

Clerk of the Supreme Court of the United States

BY /s/ LAWRENCE P. GILL
Deputy

CERTIFICATE OF SERVICE

I, R. Douglas Lackey, one of the attorneys for the Appellants herein, and a member of the Bar of the Supreme Court of the United States, hereby certify that I have this day served opposing counsel in this action with three copies of the foregoing Appendix, by depositing three copies of the same in the United States mail, with first class postage prepaid, addressed as follows:

Joseph J. Levin, Jr.
Counsel for Appellees
Southern Poverty Law Center
1001 South Hull Street
Montgomery, Alabama 36101

This ____ day of August, 1977.

R. DOUGLAS LACKEY
Assistant Attorney General